

FILED MAR 9 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6914**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1717**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY OR TOWN St. Louis, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		e. STREET ADDRESS (If rural, give location) 5253 Wabada Ave	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) A c. (Last) Maxwell		4. DATE OF DEATH (Month) (Day) (Year) Feb 15, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 30 1884
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Michael Maxwell	
13b. MOTHER'S MAIDEN NAME Mary Anne Nealan		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 492-09-3022	
17. INFORMANT'S SIGNATURE OR NAME John E Maxwell		ADDRESS 5253 Wabada Ave	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION Acute Peritonitis	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Peritonitis		INTERVAL BETWEEN ONSET AND DEATH 1 Week	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Ruptured ulcerated intestine	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Ruptured ulcerated intestine	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 578x	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Feb. 5, 1956 , to Feb 15, 1956 , that I last saw the deceased alive on Feb. 15, 1956 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.	
23a. SIGNATURE Francis J. Medley (Deacon or title) M.D.		23b. ADDRESS 4119 No. Florissant	
23c. DATE SIGNED 2/17/56		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Feb 18, 1956		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		DATE REC'D BY LOCAL REG. FEB 17 1956	
REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's ADDRESS 2849 No. Euclid Ave	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

213 MEGLER

4114 W FLORISSANT

EV 1-2783

MRS 1 PM TO 4 PM

5 PM TO 7³⁰ PM

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Albert Mayfield*.....

Licensed Embalmer No. *30*.....

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.