

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **40102**
Registrar's No. **2636**

FILED NOV 26 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **548**

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY JEFFERSON	
b. CITY OR TOWN WEBSTER GROVES		c. CITY OR TOWN HIGH RIDGE MO	
c. LENGTH OF STAY (in this place) 4YR		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION GREENWOOD SANITARIUM			
e. STREET ADDRESS (If rural, give location) MERAMEC TOWNSHIP 65001			

3. NAME OF DECEASED (Type or Print)	a. (First) CARLTON	b. (Middle) F.	c. (Last) MAXWELL	4. DATE OF DEATH (Month) (Day) (Year) NOV 5 - 1956
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWER	8. DATE OF BIRTH NOV 27 - 1879	9. AGE (In years last birthday) 76	10. MONTHS 11	11. DAYS 8	12. IF UNDER 1 YEAR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REALTOR	10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	11. BIRTHPLACE (City and State or Foreign Country) CHILLICOTHE OHIO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ALVIN H. MAXWELL	13b. MOTHER'S MAIDEN NAME ROSE DAY	14. NAME OF HUSBAND OR WIFE ANNA MAXWELL (D.F.C.)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or date of service) 493-38-1181	17. INFORMANT'S SIGNATURE OR NAME Carlton H. Miller	ADDRESS High Ridge, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Chronic Myocarditis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Webster ST. LOUIS MO.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from Feb. 22, 1955, to Nov 5, 1956, that I last saw the deceased alive on Nov. 5, 1956, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE Louis Bauer M.D.	(Degree or title) M.D.	23b. ADDRESS 2646 Gravois Ave.	23c. DATE SIGNED 11/6/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 11/8/56	24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
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DATE REC'D BY LOCAL REG. 11-7-56	REGISTRAR'S SIGNATURE Harbert B. Donahue	25. FUNERAL DIRECTOR'S SIGNATURE Funeral Home	ADDRESS House Springs Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

255-3231

255-3207

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 *John H. Brimmer*

Licensed Embalmer No... 147

P. O. Address *House Farm*

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.