

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013780
Staff File No. 658
Registrar's No. 658

FILED APR 22 1958

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 4185

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri		b. COUNTY Franklin	
b. CITY OR TOWN St. Clair		c. LENGTH OF STAY (in this place) 52 yrs		c. CITY OR TOWN St. Clair	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mill Hill Road				STREET ADDRESS (If rural, give location) Mill Hill Road	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Elias	b. (Middle) Sherman	c. (Last) Max	(Month) April	(Day) 18	(Year) 1958

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 28, 1866	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miller		10b. KIND OF BUSINESS OR INDUSTRY Milling		11. BIRTHPLACE (City and State or Foreign Country) Newton, Ill		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME David Max		13b. MOTHER'S MAIDEN NAME Isabel--		14. NAME OF HUSBAND OR WIFE Mattie Hale Max	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mattie Max		ADDRESS St. Clair, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Vascular Hypertension				years	
ANTECEDENT CAUSES		DUE TO (b)				DUE TO (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.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				General Atherosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Senile malnutrition				6 mo -	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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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)	
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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 **May 2, 1957**, to **4-18-58**, 1958, that I last saw the deceased alive on **4-17, 1958**, and that death occurred at **2:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. W. E. Kitchell M.D.		23b. ADDRESS St. Clair Mo		23c. DATE SIGNED 4-19-	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-20-58		24c. NAME OF CEMETERY OR CREMATORY City Cemetery		24d. LOCATION (City, town, or county) (State) Dixon, Mo.	
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DATE REC'D BY LOCAL REG. Apr 20 58		REGISTRAR'S SIGNATURE Floyd Williams		25. FUNERAL DIRECTOR'S SIGNATURE Casey-Lenox		ADDRESS St. Clair, Mo.	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

0360

0360

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APR 30 1958

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 *K. M. Lewis*.....
Licensed Embalmer No. *360*
P. O. Address *St. Clair*.....

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.