

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027758  
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1820

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300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>131 Plant Ave.</b>		Length of stay in 1b <b>At home</b>	d. STREET ADDRESS (If outside, give location) <b>131 Plant Ave.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>J.</b> Last <b>MAXWELL</b>			4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1891</b>	9. AGE (In years past birthday) <b>67</b>	FUNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clayton Inn</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Joseph A. Maxwell</b>		13b. MOTHER'S MAIDEN NAME <b>Fannie Kennedy</b>		14. NAME OF HUSBAND OR WIFE <b>Alletta Maxwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT Address <b>Mrs. Wm. A. Nicholson, 154 S. Maple</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstruction Ant Coronary Artery</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) <b>4201</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>11 Diabetes Mellitus (21 Ruptured Duodenal Ulcer)</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>7/14/58</b> to <b>7/7/58</b> and last saw him alive on <b>7/5/58</b> Death occurred at <b>about 3:30 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Eurd Brand MD</b> (Degree or title)			22b. ADDRESS <b>Webster Groves 19 Mo</b>		22c. DATE SIGNED <b>7/8/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-10-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cem.</b>		23d. LOCATION (City, town, or county) <b>St. Louis,</b>	(State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>Parker-Aldrich Webster Groves</b>		25. DATE RECD. BY LOCAL REG. <b>7-9-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Danks M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Leslie Welch* .....

Licensed Embalmer No. *4395* .....  
P. O. Address *Wabster Grove* .....

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.