

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038013

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9972

S. 300
v. 1-57

0

Secretary, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Watson		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 32		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LYMAN Middle DALE Last MAXWELL			4. DATE OF DEATH Month OCTOBER Day 19 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1906		9. AGE (In years last birthday) 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Bible Grove, Illinois		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles Maxwell		13b. MOTHER'S MAIDEN NAME Mary Ellen Lewis		14. NAME OF HUSBAND OR WIFE Alice Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Alice Maxwell Address Watson, Illinois		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident -					INTERVAL BETWEEN ONSET AND DEATH Acute
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					331XH
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Myeloma					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. Month, Day, Year _____					
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 September 6, 1958 , to October 19, 1958 and last saw ^{him} alive on October 19, 1958 Death occurred at 9:20 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE C. D. Hamilton, M.D. (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 10/19/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-19-58	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Arthur, Illinois
24. FUNERAL DIRECTOR C. E. Lupton & Sons ADDRESS 7233 Delmar			25. DATE RECD. BY LOCAL REG. OCT 20 '58		26. REGISTRAR'S SIGNATURE Carl Smith MD

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 *Arnold W. Schoen*

Licensed Embalmer No. *3864*
P. O. Address *St. Louis, Mo.*

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.