

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035567

STATE FILE NUMBER

Registration District No. 234 Primary Registration District No. 4349 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>MORGAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STOVER</u>		Length of stay in 1b <u>14 YRS.</u>	c. CITY OR TOWN <u>STOVER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STOVER Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>STOVER Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ASA</u> Middle <u>W. MAXWELL</u> Last <u>MAXWELL</u>			4. DATE OF DEATH <u>SEPT. 13 1960</u> Month <u>SEPT.</u> Day <u>13</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 20 1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACT</u>	11. BIRTHPLACE (City and state or country) <u>REST, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOSEPH MAXWELL</u>		13b. MOTHER'S MAIDEN NAME <u>SARA JANE SMITH</u>		14. NAME OF HUSBAND OR WIFE <u>GRACE MAXWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-10-6084</u>	17. INFORMANT <u>GRACE MAXWELL STOVER MO</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		<u>1 wk.</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>		<u>Sys.</u>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 9-6-60 to 9-13-60 and last saw ^{her}him alive on 9-13-60
Death occurred at 3:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jack Gunn MD</u> (Print or title)	22b. ADDRESS <u>Versailles, Mo.</u>	22c. DATE SIGNED <u>9-14-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STOVER CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>STOVER MO.</u>
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24. FUNERAL DIRECTOR <u>Arner Stevinson Stover Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-16-60</u>	26. REGISTRAR'S SIGNATURE <u>Wm. D. Heppner</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 20 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed J. H. Stevenson

Licensed Embalmer No. 4073

P. O. Address Boyle

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.