

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Missouri				Length of stay in 1b 5 day		c. CITY OR TOWN Newton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.F.D. # 3	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Edward Maxwell				4. DATE OF DEATH Month Day Year 9 20 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-3-49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (last birthday) 10 yr		12. CITIZEN OF WHAT COUNTRY u.s.a.	
13a. FATHER'S NAME Frank Hawn Maxwell				13b. MOTHER'S MAIDEN NAME May Woods		14. NAME OF HUSBAND OR WIFE None	
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 Vernell Kunzie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Status epilepticus DUE TO (c) Mental Depression						INTERVAL BETWEEN ONSET AND DEATH 353.2	
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 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 9-15-60 to 9-20-60 and last saw her/him alive on 9-20-60 Death occurred at 9:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Eugene P. Reese, M.D.</i> (Degree or title)				22b. ADDRESS St. Louis Childrens Hospital		22c. DATE SIGNED 9/21/60 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9-21-60		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Newton, Illinois	
24. FUNERAL DIRECTOR Reese Funeral Home ADDRESS Newton, Illinois				25. DATE RECD. BY LOCAL REG. SEP 21 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. M. Duckworth

Licensed Embalmer No. _____

P. O. Address _____

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.