

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

6045-60-046214  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>11 Yrs</b>	c. CITY OR TOWN <b>Kansas City</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>Trinity Lutheran Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>339 No White</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>SIDNEY PAUL MAXWELL</b>	4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1960</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>10/4/1924</b>	9. AGE (last birthday) <b>36</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Letter Carrier</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>US Post Office</b>	11. BIRTHPLACE (City and state or country) <b>Bowdon Ga</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Paul Maxwell</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Lanier</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Elizabeth Maxwell</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>	16. SOCIAL SECURITY NO. <b>260-28-7234</b>	17. INFORMANT <b>Mary E Maxwell 339 No White K C Mo</b>
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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>acute cardiac insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
DUE TO (b) <b>Severe coronary arteriosclerosis</b>		
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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **10-7-58** to **11-29-60** and last saw <sup>her</sup>him alive on **11-29-60**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Herbert Shuey, M.D.</b>	22b. ADDRESS <b>3903 Brooklyn K.C., Mo</b>	22c. DATE SIGNED <b>12-2-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/5/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Ft Leavenworth Kansas</b>
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24. FUNERAL DIRECTOR <b>Shell Funeral Home Kansas City Mo</b>	25. DATE RECD. BY LOCAL REG. <b>12-5-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dwyer</b>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF Herbert Shuey

Name of Deceased \_\_\_\_\_  
 Address of Deceased \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Death \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Place of Death \_\_\_\_\_  
 Name of Embalmer \_\_\_\_\_  
 Address of Embalmer \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Embalming \_\_\_\_\_  
 Name of Undertaker \_\_\_\_\_  
 Address of Undertaker \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Burial \_\_\_\_\_  
 Name of Cemetery \_\_\_\_\_  
 Address of Cemetery \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

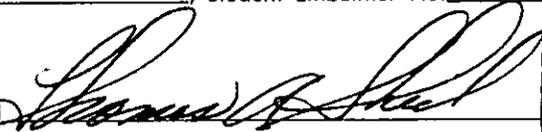
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4959

P. O. Address 1011

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.

Name of Deceased \_\_\_\_\_  
 Address of Deceased \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Death \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Place of Death \_\_\_\_\_  
 Name of Embalmer \_\_\_\_\_  
 Address of Embalmer \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Embalming \_\_\_\_\_  
 Name of Undertaker \_\_\_\_\_  
 Address of Undertaker \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Date of Burial \_\_\_\_\_  
 Name of Cemetery \_\_\_\_\_  
 Address of Cemetery \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_