

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

N 16 1961

318

Primary Registration District No. 1003

Registrar's No. 12698

60-047740
STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo. b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 1 week		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3127 Locust St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED First Middle (Type or print) LYNN B. MAXWELL (also known as) LINDIANA B. MAXWELL				4. DATE OF DEATH Month Day Year 12-28-60									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/10/1882		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Wittenberg, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Balthasar Schmitt				13b. MOTHER'S MAIDEN NAME Fredericka Schade				14. NAME OF HUSBAND OR WIFE Clarence H. 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. Nil.		17. INFORMANT Cecil H. Maxwell, 1690 Galloway Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscler Nephrosclerosis DUE TO (b) _____ DUE TO (c) Generalized Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) 446 X									
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 12-21-60 to 12-28-60 and last saw him alive on 12-28-60 Death occurred at 6:15 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) John W. Beckman, M.D.						22b. ADDRESS 5800 Arsenal			22c. DATE SIGNED 12/29/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-6-61		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery			23d. LOCATION (City, town, or county) St. Louis, Mo.						
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.				25. DATE RECD. BY LOCAL REG. JAN 6 1961		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7 8 1/2 1

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 W. W. Wilkinson

Licensed Embalmer No. 357

P. O. Address N. Low

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.