

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002135

FILED VS JAN 3 0 1961

STATE FILE NUMBER

AMENDED

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 1a

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in lb <u>14 years</u>	c. CITY OR TOWN <u>Brookfield</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>Louises Nursinh Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>627 S. Monroe Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT W. MAXWELL</u>			4. DATE OF DEATH Month Day Year <u>Jan. 23, 1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>8-18-1891</u>
9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (City and state or country) <u>Linn Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Robert Finley Maxwell</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Sturtevant</u>		14. NAME OF HUSBAND OR WIFE <u>Lillian Powell 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>None</u>	17. INFORMANT Address <u>Mrs. Lillian Maxwell, Brookfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis, acute & chronic 2 years</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Cerebral vascular accident (old)</u>			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.)	
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 <u>1-25-61</u> to <u>1-23-61</u> and last saw her <u>alive</u> on <u>1-22-61</u> Death occurred at <u>8:55 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B D Arnold M.D.</u> (Degree or title)		22b. ADDRESS <u>Brookfield, Mo</u>	22c. DATE SIGNED <u>1-24-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-25-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>
24. FUNERAL DIRECTOR <u>Wright Funeral Home, Brookfield, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-25-61</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson dep.</u>

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield 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.