

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007318

FILED VS. MAR 9 1961 *347*

STATE FILE NUMBER

5

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Stone</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Stone</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Union City Township</i>		Length of stay in 1b <i>9 years</i>	c. CITY OR TOWN <i>Billings, Route #1</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>3 miles South of Clever</i>
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Christopher</i> Middle <i>Samuel</i> Last <i>Maxwell</i>			4. DATE OF DEATH Month <i>January</i> Day <i>31</i> Year <i>1961</i>	
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 9, 1952</i>	9. AGE (last birthday) <i>9</i>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	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) <i>none</i>	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <i>Witts Springs, Ark.</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>
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13a. FATHER'S NAME <i>Huel T. Maxwell</i>	13b. MOTHER'S MAIDEN NAME <i>Anna Frances Brown</i>	14. NAME OF HUSBAND OR WIFE <i>none</i>
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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) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mr. Huel T. Maxwell, Rt. #1, Billings, Mo.</i>	Address _____
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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) <i>Bronchial Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
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 disage condition given in PART I (a): <i>Congenital deformity - Spastic, severe</i>		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 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.) <i>Spastic, severe</i>
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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 *Jan. 31, '61* to *Jan 31, '61* and last saw him alive on *Jan. 31, '61*
Death occurred at *12:20 p.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Shed R. Tommick</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>Clever, Mo.</i>	22c. DATE SIGNED <i>2-20-61</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2/3/1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Wright Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Stone County, Missouri</i>
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24. FUNERAL DIRECTOR <i>J. Alan Harris</i>	ADDRESS <i>Clever, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Feb. 27 - 61</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. J. Edmer Brasseur</i>
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pl. Lena Murray

DATE AMENDED

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 J. Alan Harris

Licensed Embalmer No. 4390

P. O. Address. Cleves, 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.