

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-034681

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8701 STATE FILE NUMBER

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>			Length of stay in 1b		c. CITY OR TOWN <u>Ferguson</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>24 S. Barat Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOY E. MAXWELL</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 17 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/1/1873</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>6 16</u>	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Arnold Withmor</u>			13b. MOTHER'S MAIDEN NAME <u>Grace Parker</u>		14. NAME OF HUSBAND OR WIFE <u>John K. Maxwell D'ced</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>William K. Maxwell 2 Country Fair Lane</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>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>420.0F</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>AVULSION FRACTURE OF LEFT GREAT TROCHANTER</u>						INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT <input checked="" 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.) <u>PATIENT FELL IN HER HOME</u>	
20c. TIME OF INJURY <u>???</u> Hour a.m. p.m. <u>One Week prior to admission</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. CITY, TOWN, OR LOCATION <u>FERGUSON</u>		COUNTY <u>MISSOURI</u>		STATE	
21. I attended the deceased from <u>SEPT. 3, 1961</u> to <u>SEPT. 17, 1961</u> and last saw her/him alive on <u>SEPT. 17, 1961</u> Death occurred at <u>6:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>[Signature] M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>9/18/61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		24. FUNERAL DIRECTOR <u>Ambruster Mortuary 6633 Clayton Road</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 19 1961</u>		26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 *Paul J. Hammer*

Licensed Embalmer No. 4788

P. O. Address St. Louis, 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.