

Registration District No. 560

Primary Registration District No. 6094

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Shelby Missouri

(b) City or town Clarence Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 10 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JOSEPH E. MAXWELL 240

3. (b) If veteran name war no

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3  
year 1940 hour 51 minute 0 M.

4. Sex Male

5. Color or race White

6. (a) Name of husband or wife Lizzie Maxwell

6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased 2 (Month) 3 (Day) 1852 (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on April 10, 1940 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>3</u>	<u>0</u>	by _____ min.

Immediate cause of death Uremia

9. Birthplace Cynthiana Ohio  
(City, town, or county) (State or foreign country)

Due to Prostate Hypertrophy

Due to \_\_\_\_\_

10. Usual occupation Farmer

Other conditions Secularity  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Joseph Maxwell

13. Birthplace Moine  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Smith

15. Birthplace New York  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Fred Vickers

(b) Address Clarence Mo

17. (a) Burial (b) Date thereof 5-5-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant Park Ill

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 751  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director William Burkholder

(b) Address Clarence Mo

19. (a) May 3 1940 (b) Woy Hamilton  
(Date received local registrar) (Registrar's signature)

23. Signature Frank Roy (M. D. or other) 1

Address Clarence Mo Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 6-40-1208

Date Filed JUN 12 1940

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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Henry G. Bartelme*

Licensed Embalmer No.

3835

P. O. Address

*Shelburne, Md.*

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 this body is not embalmed, above space should be left blank.