

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH157  
State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>7</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u> c. LENGTH OF STAY (in this place) <u>8 DAYS</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>ELLIS FISCHAL STATE CANCER HOSP.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u> c. CITY OR TOWN <u>CARTHAGE</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>322 N. ORNER ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>SMART</u> c. (Last) <u>MAXWELL</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>11</u> (Year) <u>55</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>/</u>		8. DATE OF BIRTH <u>11-9-24</u>		9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ROGERS, ARK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANDREW JACKSON MAXWELL</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZA JANE WOOD</u>		14. NAME OF HUSBAND OR WIFE <u>TERRY ANN MAXWELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORDS</u> ADDRESS <u></u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Epid. C.A. hypopharynx</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>-</u> DUE TO (c) <u>-</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral edema</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>1/3/55</u> , 19 <u>55</u> , to <u>1/11/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/11/55</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>J.B. Bladen</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>EFSCA, Columbia Mo.</u>		23c. DATE SIGNED <u>1/11/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-12-1955</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>CARTHAGE, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 12 1954</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmieri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Therese Funeral Service, Columbia Mo.</u> ADDRESS <u></u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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. W. Phillips*

Licensed Embalmer No. *489*

P. O. Address *Columbia*

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.