

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

35405

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. ....

Registered No. **10591**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **321 R 2** St., **W** Ward.

Length of residence in city or town where death occurred **40** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** **male** **4. COLOR OR RACE** **white** **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** **Single**

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** **Don't know**

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **abt. 67**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Laborer**  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** **Connecticut**

**10. NAME OF FATHER** **Luke Madden**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** **Don't know**

**12. MAIDEN NAME OF MOTHER** **Kate ?**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** **Don't know**

**14. INFORMANT (Address)** **St. Joseph Hospital**  
**Roman**  
**City Hospital**

**15. FILED** **NOV 26 1927** **Max B. Starkeoff** REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** **Nov 12 1927**

**17. I HEREBY CERTIFY** That I attended deceased from **Oct 27**, 19**27** to **Nov 12**, 19**27** that I last saw him on **Nov 12**, 19**27**, and that death occurred, on the date stated above, at **6:30 p.m.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Chronic Myocarditis**

**CONTRIBUTORY (SECONDARY)** **acute Peritonitis**

**18. WHERE WAS DISEASE CONTRACTED** **Not at place of death**

**DID AN OPERATION PRECEDE DEATH?** **yes** DATE OF **11/9/27**

**WAS THERE AN AUTOPSY?** **no**

**WHAT TEST CONFIRMED DIAGNOSIS?** **clin. Lab. & operation**

(Signed) **Robert W. Simpson**, M. D.

**12**, 19**27** (Address) **City Hospital**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** **St. Mary Cemetery** **Nov 26 19 27**

**20. UNDERTAKER** **J. H. Gebken 2842 Marquette**

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

Madden

Name: Bernard Madden  
Who died at: St. Louis, Mo. on Nov. 12, 1927,

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Chronic myocarditis

Contributory: acute Parotitis - see notes  
not Mumps

Where was disease contracted? \_\_\_\_\_

Did operation precede death? yes - for acute Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

Name of physician: Robert W. Simpson

S-35405