

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

**37384**  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Stoddard Registration District No. 837  
 (b) Township Gaster Primary Registration District No. 4508 Registered No. ....  
 (c) City Bloomfield (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** 350 HOHN C. MADDEN

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Florence Madden  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10, 1861  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
78 3 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
 9. Industry or business in which work was done, as saw mill, bank, etc. ....  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

FATHER 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT William T. Madden  
 (ADDRESS) Bloomfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bloomfield Cem. DATE Oct. 16, 1939

19. FUNERAL DIRECTOR (NAME) Chiles Und. Co.  
 (ADDRESS) Bloomfield, Mo.

20. FILED Oct. 16, 1939 Loonie Punch  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1939 to Oct 17, 1939  
 I last saw him alive on Oct 12, 1939 Death is said to have occurred on the date stated above, at 5 p.m.  
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis  
myocardial degeneration  
 Date of onset ?  
 Other contributory causes of importance:  
Broncho pneumonia  
Arterial Sclerosis

Name of operation None Date of .....  
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify .....  
 (Signed) W. G. Davis, M. D.  
8:5 (Address) Bloomfield, Mo.

N. B.—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.

**RECEIVED**

District Health Officer No. 2

District File Number 1139-321

Date Filed 11-8

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**