

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

~~FILED~~ AUG 19 1940

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

28372
Do not use this space.

1. PLACE OF DEATH
(a) County Dallas Registration District No. 24
(b) Township Buffalo Primary Registration District No. 414
(c) City Buffalo (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John I Maddux
(a) Residence, No. 3703 Buffalo Mo. 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 Effie Maddux

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-3-1876

7. AGE YEARS 64 MONTHS 4 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Merchant
9. Industry or business in which work was done, as saw mill, bank, etc. dry Goods Store
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) Mo. 0

FATHER 13. NAME J. K. P. Maddux
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER 15. MAIDEN NAME Maitha a. Southern
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

17. INFORMANT James Maddux
(ADDRESS) J. Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 9-29-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones
Buffalo Mo. 215

20. FILED 9/13 1940 Harry Warren
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-28 1940

22. I HEREBY CERTIFY, That I attended deceased from July 9, 1940, to Aug. 28, 1940
I last saw him alive on Aug. 28, 1940. Death is said to have occurred on the date stated above, at 6:32 a.m.
The principal cause of death and related causes of importance were as follows:
Meningitis
Other contributory causes of importance:
Conjunctivitis
Paralytic Agitation

Date of onset Aug. 26
Aug. 19

Name of operation _____ Date of _____
What test confirmed diagnosis? Usual Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1940
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? no
If so, specify _____
(Signed) C. Williams M. D.
(Address) Buffalo, Mo.

[OCT 25 1954]

~~OCT 22 1954~~

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1306

Date Filed 9-11-40

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28372**
Registrar's No. **1269**

Registration District No. **241**

Primary Registration District No. **4147**

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

1. PLACE OF DEATH:

(a) County **Dallas**

(b) City or town **Buffalo**
(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 _____
years, months or days

3. (a) PRINT FULL NAME **John J. Maddy**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **w**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **Apr 2 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	4	26	_____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Oct 5-40** (b) **Harvey Morrow**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Dallas**

(c) City or town **Buffalo**
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **28**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature **E. L. Williams** (M. D. or other) _____
Address **Buffalo mo** Date signed _____

SUPPLEMENTAL

