No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38152

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1184

FILED DEC 10 1940

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 10 mo. 16 da (Specify whether
In this community years, months or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
Street No. 514 S. 17th Street (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME BENJAMIN FRANKLIN MADISON

3. (b) If veteran, name war ?
3. (c) Social Security No. none

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Separated
6. (b) Name of husband or wife ?
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased March 2, 1868 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
72	8	6	hr. min.

9. Birthplace Gallatin, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Barber 0
11. Industry or business 1
FATHER
12. Name Joshua Madison
13. Birthplace Kentucky (City, town, or county) (State or foreign country) 1
MOTHER
14. Maiden name Louise Harts
15. Birthplace Maryland (City, town, or county) (State or foreign country)
16. (a) Informant State Hospital Records
(b) Address St Joseph Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-40 (Month) (Day) (Year)
(c) Place: burial or cremation St Hosp #2
18. (a) Signature of funeral director John E. Rupp
(b) Address 6054 Prior Ave
19. (a) 11/13/40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8 year 1940 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Date of Admission Dec. 21, 1938, 19 to Nov. 7, 1940 that I last saw him alive on November 7, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to 1908

Due to

Other conditions Heart Disease (Include pregnancy within 3 months of death)
Arteriosclerotic

Major findings:
Of operations
Of autopsy Lobar Pneumonia
Degenerative Heart Disease

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

23. Signature P. S. Tate (M. D. or other) MD
Address State Hosp #2 St Joseph Date signed 11-8-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed not ~~by me, or by~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, T

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, fact should be so stated above.