

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 JAN 23 1941

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

44079  
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 840 ✓  
(b) Township Duck Creek Primary Registration District No. 6102 Registered No. 39  
(c) City Poplarville (d) Street No. \_\_\_\_\_ St.  
(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.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (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) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 3 - 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
73 9 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer.  
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) Indiana,

FATHER 13. NAME James D. Madden

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana!

MOTHER 15. MAIDEN NAME Mary Elizabeth Martin

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

17. INFORMANT (ADDRESS) Charlie Hancock  
Poplarville - Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Rock Hill DATE 12-17-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Matthews Funeral Home  
Poplarville - Mo

20. FILED 12-17 1940 DeMars Super  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-16-1940

22. I HEREBY CERTIFY, That I attended deceased from 12, 15 1940, to 12, 15, 1940  
I last saw him alive on 12, 15, 1940. Death is said to have occurred on the date stated above, at 8:00 A. m.  
The principal cause of death and related causes of importance were as follows:

Chronic Pulmonary tuberculosis of both lungs. Date of onset 43  
Other contributory causes of importance: Tuberculosis Peritonitis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis Clinical 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 \_\_\_\_\_, 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) Dr. John W. Nelson, D.  
(Address) Poplarville, Mo

RECEIVED

District Health Officer

District File Number 141

Date Filed 1/8/17

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,

Virgil H. Kelch

, or by

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

Signed

Virgil H. Kelch

Licensed Embalmer No.

4102

P. O. Address

Deerfield - Mo.

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.



