

FILED APR 2 1943 40

State File No.

Registration District No.

Primary Registration District No. 5826

Registrar's No. 60

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town De Forest
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community About 20 years (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town De Forest
(If outside city or town limits, write "RURAL")

(d) Street No. 4 miles N. of Marston
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LULA MADISON

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1943 hour 8:00 minute _____ P. M.

4. Sex FEMALE 5. Color or race Black

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FRED MADISON

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Aug 15 - 1902
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 11
1942 to March 23 1943

that I last saw her alive on March 23 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

40 7 8 _____ hr. _____ min.

Immediate cause of death Influenza Duration 5 days

Due to Emphysema 8 mos

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

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

Major findings: _____

Of operations _____

Of autopsy _____

10. Usual occupation Housewife

11. Industry or business _____

12. Name unk

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

14. Maiden name unk

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Fred Madison

(b) Address Portageville, R. 1, B. 21

17. (a) Burial (b) Date thereof 3-25-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic

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? _____

18. (a) Signature of funeral director Richards and Co

(b) Address New Madrid, Mo.

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Edward M Poff (M. D. or other) _____

Address Marston Date signed 3-25-43

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

APR 19 10 23

FEB 13 1957

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

Lo Higginbotham

Licensed Embalmer No.

3803

P. O. Address

New Madrid 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10944
Registrar's No. 60

Registration District No. 240

Primary Registration District No. 2826

1. PLACE OF DEATH:

- (a) County New Madrid
- (b) City or town La Farge
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lula Madecian

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Aug 15
(Month) (Day) (Year)

8. AGE: Years 40 Months 7 Days _____
If less than one day min.

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

10. Usual occupation _____

11. Industry of 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) May 1-1943 (b) Mrs. J. K. Barrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, write "RURAL.")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1943 hour _____ minute _____ M.

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

Immediate cause of death Influenza 5 days
Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-10944