S. No. 2
M—2-43
17-39
X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 28 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29352

State File No.

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1909

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(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

2. USUAL RESIDENCE OF DEACESED:
(a) State Missouri (b) County 000 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4644 Maffitt Ave.,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3. (a) PRINT FULL NAME Walter Maddox
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced /
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 26th 1874 (Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 24 If less than one day hr. min.

9. Birthplace St. Louis, Mo., (City, town, or county) 0 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Thomas Maddox
13. Birthplace St. Louis, Mo (City, town, or county) 0 (State or foreign country)
MOTHER 14. Maiden name Elizabeth Callan,
15. Birthplace West Virginia (City, town, or county) / (State or foreign country)
16. (a) Informant Mrs. Wm. Richter
(b) Address 4644 Maffitt Ave.,
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8-23-43 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Sullivan Brothers
(b) Address 2849 No. Euclid Ave.,
19. (a) AUG 23 1943 (Date received local registrar) (b) C. J. McGuran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20 year 1943 hour 8:40 minute P M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Struck by an automobile while a pedestrian on a public highway.	
Due to Laceration of scalp; Mult. abrasions and contusions;	
Due to Subarachnoid hemorrhage; Mult. contusions of brain;	
Other conditions Frac. right arm. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes. 170C-4 21

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) Accident. 096
(b) Date of occurrence August 17, 1943
(c) Where did injury occur? 8800 Natural Bridge Rd. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)
While at work? (e) Means of injury
23. Signature Louis H. Bopp Coroner (M. D. or other)
Address Kirkwood, Mo. 8-21-43 Date signed

(Licensed Embalmer's Statement on Reverse Side)

AUG 30 1943

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, fact should be so stated above.

S. No. 2B
DM—5-43
I X36930

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1909

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution St Louis Co - Hosp
(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)

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

3. (a) PRINT FULL NAME Walter Maddox

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 (M.)

6. (b) Name of husband or wife (Unkn.)

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

7. Birth date of deceased July (Month) 26 (Day) 87 (Year)

8. AGE: Years 69 Months 0 Days 24 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) C. H. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 20 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

29353