No. 2
1—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5457

State File No.

FILED MAR 13 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2059

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: HOMER PHILLIPS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 DAYS (Specify whether

In this community LIFE
years, months or days)

2. USUAL RESIDENCE OF DEACESED: 000

(a) State MO (b) County 1291

(c) City or town ST LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 2656 LUCAS AVE.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME ARTHUR MADDEN.

3. (b) If veteran name war WORLD WAR

3. (c) Social Security No.

4. Sex MALE 5. Color or race C 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife

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

7. Birth date of deceased 6 (Month) 14 (Day) 1886 (Year)

8. AGE: Years 57 Months 8 Days 14 If less than one day hr. min.

9. Birthplace ST LOUIS (City, town or county) MO (State or foreign country)

10. Usual occupation LABORER

11. Industry or business

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

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

16. (a) Informant SARAH MAY
(b) Address 2656 LUCAS AVE

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

18. (a) Signature of funeral director BERNIE LAYE
(b) Address 3103 WASHINGTON

19. (a) MAR 1 1944 (Date received local registrar) J. F. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 28 year 1944 hour 2 minute 20 A.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 LOBAR PNEUMONIA, RIGHT FORMIS WHEN A BUILDING HEIGHT FALLING TO WRECK COLLAPSED BURYING HIM UNDER THE DEBRIS AT 1114-1113 Due to 13 AT ABOUT 3:00 PM FEB 16 1944

Duration

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) ACCIDENT
(b) Date of occurrence FEB 16 1944
(c) Where did injury occur? ST LOUIS MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? INDUSTRIAL
(Specify type of place)
While at work? YES (e) Means of injury COLLAPSED BUILDING

23. Signature THOMAS F. CALLAHAN (M. D. or other)
Address DEPUTY CORONER Date signed 3-4-44

(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 by me, or by .....

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

working under my personal supervision.

Signed Arthur R. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4219 E Garfield

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.