

44-1-P-20  
15685

Registration District No. 5/6

Primary Registration District No. 6074

1. PLACE OF DEATH:

(a) County ST. FRANCOIS  
(b) City or town LEADWOOD *Ranchdale Hwy*  
(c) Name of hospital or institution:  
NONE  
(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) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. FRANCOIS  
(c) City or town LEADWOOD  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN HENRY MADIGAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced 1

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

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

8. AGE: Years Months Days If less than one day  
71 8 \_\_\_\_\_ hr. min.

9. Birthplace MO. MO. A  
(City, town, or county) (State or foreign county)

10. Usual occupation Interior Decorator

11. Industry or business \_\_\_\_\_

12. Name MICHAEL MADIGAN

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

14. Maiden name MARY JOHNSON

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

16. (a) Informant \_\_\_\_\_

(b) Address Leadwood Mo.

17. (a) Burial (b) Date thereof April 29 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEADINGTON

18. (a) Signature of funeral director J. S. Boyer, Esq.

(b) Address Leadwood Mo.

19. (a) 4-28-44 (b) James P. Robin  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26  
year 1944 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 18  
1944 to April 26 1944  
that I last saw him alive on April 26 1944  
and that death occurred on the date and hour stated above

Immediate cause of death arteriosclerotic Cardiovascular Disease Duration 6 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 93d

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 John W. Hunt (M. D. or other) \_\_\_\_\_

Address Leadwood Mo. Date signed 4/27/44

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

2  
41  
39  
29484

1375

RECEIVED 5-13-44

District Health Officer No. 4

District File Number 544-3855

Date Filed 5-13-44

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**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 Bert L. Boyer

Licensed Embalmer No. 30445

P. O. Address Leadwood, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2249  
Registrar's No. \_\_\_\_\_

Registration District No. 316 Primary Registration District No. 6074

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

1. PLACE OF DEATH:  
(a) County St. Francis  
(b) City or town Leadwood, Randolph Co.  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME John Henry Madegan  
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 Divorced  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased: Aug 26  
(Month) (Day) (Year)  
8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
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)

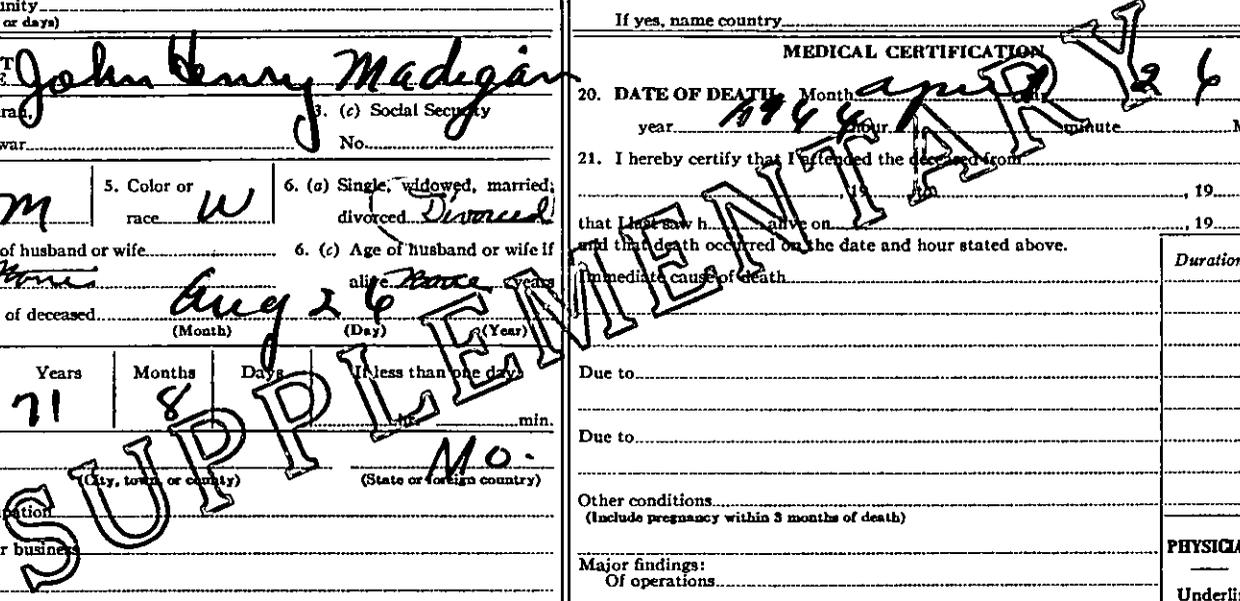
16. (a) Informant Mamie Catlett  
(b) Address Leadwood Mo.  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director J. B. Bayless  
(b) Address Leadwood Mo.  
19. (a) 4-28-44 (b) Barbara K. Korman  
(Date 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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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 \_\_\_\_\_

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 \_\_\_\_\_



PHYSICIAN  
Underline the cause to which death should be charged statistically.

15685