

LED JUL 13 1944

Registration District No. **20**

Primary Registration District No. **4194**

Registrar's No. **70**

1. PLACE OF DEATH:

(a) County **DeWitt**
(b) City or town **Albany**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Missouri** (b) County **DeWitt** **38**
(c) City or town **Albany** **1**
(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 **Estey Myrtle Madden**

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

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **H. T. Madden** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **Oct. 1 - 1886**
(Month) (Day) (Year)

8. AGE: Years **58** Months **8** Days **17** If less than one day _____ hr. _____ min.

9. Birthplace **Albany Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Ed. Nicholson**
13. Birthplace **Franklin Ky** (City, town, or county) (State or foreign country)
14. Maiden name **Georgia Campbell**
15. Birthplace **Franklin Ky** (City, town, or county) (State or foreign country)

16. (a) Informant **H. T. Madden**
(b) Address **Albany, Mo.**

17. (a) **Burial** (b) Date thereof **6/18/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Franklin Ky**

18. (a) Signature of funeral director **W. H. ...**
(b) Address **Albany Mo**

19. (a) **6-19-1944** (b) **Donald M. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17**
year **1944** hour **3** minute **A.M.**

21. I hereby certify that I attended the deceased from **May 11**
1944 to **June 17** 19**44**
that I last saw him alive on **June 17** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Carcinoma of Intestine
Due to **Metastases**
Due to **(Carcinoma of Intestine)**
Other conditions _____
(Exclude pregnancy within 3 months of death)

Major findings: _____
Of operations **H&I**
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. N. ...** (M. D. or other)
Address **Albany Mo** Date signed **6-18-44**

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

28 - 1 - 0

1109

16-18-44

7
2

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

Signed Charles B. Baker
Licensed Embalmer No. 3329
P. O. Address Albany NY

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.