No. 2
M—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30849

FILED OCT 10 1944

Registration District No. 6

Primary Registration District No. 3020

Registrar's No. 86

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

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town 36
(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 Fairy Darlene 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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. (Month) 22 (Day) 1944 (Year)

8. AGE: Years | Months | Days | If less than one day 6 hr. 10 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Donald Adair Madden
13. Birthplace Jefferson City (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Pearl Bluebell Sams
15. Birthplace Alva (City, town, or county) Oklahoma (State or foreign country)

16. (a) Informant Dan Madden
(b) Address Pacific Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Pacific Mo

18. (a) Signature of funeral director Wm L Thiebes
(b) Address Pacific Mo

19. (a) Sept 22/44 (Date received local registrar) (b) Lucille R. Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1944 hour 10 minute 40 A. M.

21. I hereby certify that I attended the deceased from 9/22/44 4 30 AM 19 9/22/44 10 40 AM 19 that I last saw her alive on 9/22 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral injury

Due to Large baby 3 weeks overtime.

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.

160

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 [signature] (M. D. ~~or other~~)

Address Washington, Mo Date signed 9/22/44

1181

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9

District File Number
Date Filed 10-9-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was Not embalmed ~~by me, or by~~
, ~~Registered Apprentice No.~~
~~working under my personal supervision.~~

Signed Jno. L. Shelles

Licensed Embalmer No. 3008

P. O. Address Pacific, 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.

S. No. 2B
M—5-43
I X36930

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

State File No. Oct

Registration District No. 416 Primary Registration District No. 3020 Registrar's No. 86

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Franklin
(c) City or town Pacific
(If outside city or town limits, write "RURAL")
(d) Street No. 210 So. 5th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Fairy D. Madden
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 22 1844 (Month) (Day) (Year)
8. AGE: Years Months Days 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) Lucille R. Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 22 year 1944 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 — 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

30849