

FILED JAN 25 1945

Registration District No.

1003

Registrar's No.

508

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: Barnes Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry
 (c) City or town Monett
 (If outside city or town limits, write "RURAL") NR!
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME LESLIE ARTHUR MADEWELL

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Josephine Madewell 6. (c) Age of husband or wife if alive 38 years
 7. Birth date of deceased December 31 1897
 (Month) (Day) (Year)

8. AGE: Years 47 Months 0 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Ownerr Grocery Store

11. Industry or business

MOTHER FATHER { 12. Name Thomas Madewell
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Minnie McCubbin
 15. Birthplace Unknown Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L.A. Madewell
 (b) Address Monett, Missouri

17. (a) Burial (b) Date thereof 1-20-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monett, Missouri
 18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) JAN 17 1945 J. F. Bradick
 (Date) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17
 year 1945 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 12 1945 to Jan 17 1945
 that I last saw him alive on Jan 17 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure - Congestive

Due to Overwhelming infection type to be determined by further examination (post-mortem)

Other conditions 95C
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy not yet complete.

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 A. R. Bradley (M. D. or other)
 Address Barnes Hospital Date signed 1/17/45

5
2
NR!

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Albert G. Kapp

Licensed Embalmer No.....

2977

P.O. Address.....

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.