

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2325

FILED JUN 11 1945
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 5331 Highland, Little Sisters of the Poor
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years
(Specify whether years, months or days)
 In this community 2 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 Street No. 5331 Highland
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME DANIEL MADDEN
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 27th day May
 year 1945 hour 4:00 minute P M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 25 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 1944 19. to May 27th 1945 19. ;
 that I last saw him alive on May 27, 1945 19. ;
 and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>79</u> | <u>7</u> | <u>2</u> | hr. _____ min. _____ |

Immediate cause of death Chronic Myocardosis
 Duration Years?

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

Due to Cardiac Decompensation 3 Months

10. Usual occupation None

Due to Generalized Arterio-sclerosis-15 years

11. Industry or business _____

Other conditions _____
(Include pregnancy within 3 months of death)

12. Name Mathias Madden
 13. Birthplace No record
(City, town, or county) (State or foreign country)

Major findings: 93 d
 Of operations _____

14. Maiden name Mary Moran
 15. Birthplace No record
(City, town, or county) (State or foreign country)

Of autopsy No
 Underline the cause to which death should be charged statistically.

16. (a) Informant Some Sisters of the Poor
 (b) Address 5331 Highland

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (b) Date thereof 5/31/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Mary's Cemetery

(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? _____

18. (a) Signature of funeral director Durk's & Son Co
 (b) Address 20 West Linwood

While at work? _____ (Specify type of place)
 (c) Means of injury 0

19. (a) 5-30-45 (b) St. Geraldine Home
(Date received local registrar) (Registrar's signature)

23. Signature John T. Skinner (M. D. or other) M.D.
 Address 1402 Bryant Bldg Date signed 5/27/45

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.....

Charles M. Quinn

Licensed Embalmer No.....

3774

P. O. Address.....

F. C. No

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.