

Registration District No. 149 Primary Registration District No. 1002

**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:  
General Hospital 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 20 days  
 In this community 24 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Earl Madden  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

4. Sex Ma 0 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Divorced 0  
 6. (b) Name of husband or wife unknown  
 6. (c) Age of husband or wife if alive 15 years  
 7. Birth date of deceased February 15 1884  
 (Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 5  
 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER  
 12. Name Robert Madden  
 13. Birthplace Pa 1  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Althea McMann  
 15. Birthplace Iowa 1  
 (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records  
 (b) Address K.C. General Hospital  
 17. (a) Removal (b) Date thereof 8-21-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Creston, Iowa

18. (a) Signature of funeral director J.W. Wagner  
 (b) Address Kansas City, Mo.

19. (a) 8-20-45 (b) St. Pauline Holman  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson 47  
 (c) City or town Kansas City 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Helping Hand Institute 7  
 (If rural, give location)  
 (e) Citizen of foreign country? No 0 (Yes or No)  
 If yes, name country

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month August 20  
 year 1945 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from July 30, 1945 to August 20, 1945  
 that I last saw him alive on August 20, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency  
uremia (M.M.O. (N.M.O.))

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 132.2  
 Of operations  
 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 Clark W. Seely (M. D. or other)  
 Address Med. Dir. K.C. General Hospital

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

**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.....

*Cecil R. Mattkes*....., Registered Apprentice No. *3807*  
working under my personal supervision.

Signed..... *Cecil R. Mattkes*

Licensed Embalmer No. *3807*

P. O. Address *3309 Penn*

**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.**