

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6441

State File No. 1748

BIRTH NO. REG. DIST. NO. 1003 PRIMARY REG. DIST. NO. 1003 Registrar's No.

12

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital 0		d. STREET ADDRESS (If rural, give location) 5060 Cabanne Ave. 0	
3. NAME OF DECEASED (Type or Print) a. (First) Ann b. (Middle) c. (Last) Madden		4. DATE OF DEATH (Month) (Day) (Year) Feb. 22, 1949	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH Unk. Unk. 1880-AG-89
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. (1)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Peter T. Madden		13b. MOTHER'S MAIDEN NAME Catherine Kane	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rev. Rowland E. Gannon, 3854 Flad Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pelvic abscess INTERVAL BETWEEN ONSET AND DEATH 7 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sigmoid diverticulitis many years DUE TO (c) Cause unknown / h. 3 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal point only 1 day	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No operation 5/24	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/15, 1949, to 2/22, 1949, that I last saw the deceased alive on 2/22, 1949, and that death occurred at 12:07 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Arthur J. Donnelly M.D.		23b. ADDRESS 1117 N Grand	
23c. DATE SIGNED 2/23/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Feb. 25, 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) St. Louis, Mo.		24e. (State)	
DATE REC'D BY LOCAL REG. FEB 24 1949		REGISTRAR'S SIGNATURE J. B. Kasater	
25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	

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.

Student Embalmer No. _____

Signed _____

Thomas R. Renwick

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3793

P. O. Address _____

3840 Linden

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.