

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Star File No. **42359**

FILED DEC 22 1953

BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **150**

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CLAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 801 DUNBAR		d. STREET ADDRESS (If rural, give location) 801 DUNBAR 6RD 0	

3. NAME OF DECEASED (Type or Print)	a. (First) MINNIE	b. (Middle) E. O.	c. (Last) MADDEN	4. DATE OF DEATH (Month) (Day) (Year) DEC. 6 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 16 1887	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 100 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOUSEKEEPING	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME JOHN S. LEWIS	13b. MOTHER'S MAIDEN NAME MINERVA DALE	14. NAME OF HUSBAND OR WIFE CHARLES W. MADDEN
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME CHARLES W. MADDEN	ADDRESS 801 DUNBAR EXCELSIOR SPRINGS, MO.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension + arterial sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DOE TO (b) cerebral accident		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. acute pulmonary edema		10 min.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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
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22. I hereby certify that I attended the deceased from **4-1**, 19**53**, to **12-6**, 19**53**, that I last saw the deceased alive on **12-6**, 19**53**, and that death occurred at **11:59** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Miss Margaret M.D.	23b. ADDRESS Excelsior Springs, Mo.	23c. DATE SIGNED 12-9-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-9-53	24c. NAME OF CEMETERY OR CREMATORY MASONIC	24d. LOCATION (City, town, or county) (State) EXCELSIOR SPRINGS, MO.
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DATE REC'D BY LOCAL REG. 12/9/53	REGISTRAR'S SIGNATURE Caroline Hutchings	25. FUNERAL DIRECTOR'S SIGNATURE Claude Prichard	ADDRESS Excelsior Springs, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Carla Lynch

MAR 11 1954

FEB 16 1954

FEB 10 1954

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.....
Student Embalmer

Signed *Lindell K. Jansen*

Licensed Embalmer No. *4589*

P. O. Address *Exelior Springs*

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.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

The Division of Health of Missouri
BUREAU OF VITAL STATISTICS

State of **Missouri**

State File No. **42359**

County of **Clay**

ss.

AFFIDAVIT FOR CORRECTION OF A RECORD Local Registrar's No. **150**

On this **8th** day of **March**, 19**54**, before me appears

Charles W. Madden, who, upon **his** oath, states that the original record of ~~xxx~~ death

for **Minnie L. Madden**, died **December 6**, 19**53**, in the State of

Missouri, and which was filed at **Excelsior Springs Dec. 9, 53**, should be corrected as follows:

Item No. **3** should read **Minnie D. Madden**

Instead of **Minnie L. Madden**

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant **Charles W. Madden** ~~husband~~

801-Dubas Excelsior Spgs. Mo

Relationship.

Present Address.

Subscribed and sworn to before me this **8th** day of **March**, 19**54**.

My Commission expires **1-14-56**

Ernest J. Litus Notary Public.

NO FEE
ENCLOSED
MAR 10 1954

