

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33841

FILED SEP 26 1957

STATE FILE NUMBER 8571

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300  
-57 0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS <b>831 Harlan Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>ELEANOR</b> Last <b>MADSEN</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>12,</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1st, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Chicago, Ill</b>	
13a. FATHER'S NAME <b>Frank Gawlik</b>		14. NAME OF HUSBAND OR WIFE <b>Louis E. Madsen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>318-05-8011</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF OVERY WITH METASTASES</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>175x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YR.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21a. attended the deceased from <b>AUG. 23, 1957</b> to <b>SEPT. 12, 1957</b> and last saw her alive on <b>SEPT. 12, 1957</b>		22a. SIGNATURE <i>C. Vermillion, M.D.</i> (Degree or title) M.D.	
22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>9/12/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>9/16/57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemtery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo</b>	
24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 13 '57</b>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i> <b>msb.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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~~ ..... Student-Embalmer No. ....  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elton H. Renel

Licensed Embalmer No. 4283  
P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.