

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37812

FILED OCT 28 1957

1003

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

Registrar's No.

9422

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Richmond Heights	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS (If outside, give location) 5226 Southwood Ave.	
3. NAME OF DECEASED First Middle Last Elizabeth Ida Madden			4. DATE OF DEATH Month Day Year Oct. 6, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE STATUS NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
10a. FATHER'S NAME Michael Cronin		10b. MOTHER'S MAIDEN NAME Johanna O'Brine	10c. NAME OF HUSBAND OR WIFE Alphonse J.
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		12. SOCIAL SECURITY NO. None	13. INFORMANT Alphonse J. Madden 6226 Southwood
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>and atheroscler. heart disease.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>			15. INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> 16. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
17a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
18. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 1, 1956</u> , to <u>Oct. 6, 57</u> , and last saw her alive on <u>10/6/57</u> Death occurred at <u>8:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>J. M. Javan M.D.</u> ADDRESS <u>539 N. Grand St. St. Louis</u> DATE SIGNED <u>10/8/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-10-57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Chas. F. Stuart 1225 Union Bl.		25. DATE RECD. BY LOCAL REG. OCT 9 57	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> mgs

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Elmo R. Padua*.....

Licensed Embalmer No. *4077*.....  
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.