

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001957
STATE FILE NUMBER

FILED JAN 26 1958 Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 1

300
-57

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pipley	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Pine	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State Sanatorium		Length of stay in 1b 17 days	d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Albert Middle Marion Last Madison	4. DATE OF DEATH Month Jan. Day 9, Year 1959
---	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1892	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	---	--

13a. FATHER'S NAME James Madison	13b. MOTHER'S MAIDEN NAME Eliza Green	14. NAME OF HUSBAND OR WIFE Clora Madison
--	---	---

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. 498-10-1282	17. INFORMANT Address San.records,Mo.State San.,Mt.Vernon,Mo.
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic progressive pulmonary histoplasmosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
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)		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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--	--

21. I attended the deceased from 12-23-58 to 1-9-59 and last saw him alive on 1-9-59 Death occurred at 3:53 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) J. Lewis Yates, M.D.	22b. ADDRESS Mo. State Sanatorium, Mt. Vernon, Mo.	22c. DATE SIGNED 1-9-59
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-9-59	23c. NAME OF CEMETERY OR CREMATORY OAK RIDGE CEMET.	23d. LOCATION (City, town, or county) (State) Alton, Mo.
---	----------------------------	---	--

24. FUNERAL DIRECTOR H. D. Fossett, Mt. Vernon, Mo.	25. DATE RECD. BY LOCAL REG. 1-12-59	26. REGISTRAR'S SIGNATURE Carl Handricka
---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 27 1964

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed H. R. Torrance.....

Licensed Embalmer No. 2201.....

P. O. Address MT Vernon.....

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.