

Health,
& Welfare
Public
Service

FILED VS AUG 7 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-027714

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1953

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
e. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic</u>		Length of stay in 1b <u>11 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>3236 Texas</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Madden</u> Last			4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>	
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1889</u>	9. AGE (In years last birthday) <u>70</u>	10. F UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Cramer</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Fay</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Madden</u>	
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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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Genevieve Lettich</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>		
DUE TO (c) <u>Chenitry + Sealed with Mellitus</u>		<u>yes.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>287X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <u>July 7 1959</u> to <u>July 19 59</u> and last saw her alive on <u>July 18 1959 4pm</u> Death occurred at _____ in on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree optional) <u>Ernest Slaughter D.O.</u>	22b. ADDRESS <u>2 Ashby St. Amer Mo</u>	22c. DATE SIGNED <u>7-19-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JULY 21 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO</u>
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24. EMBALMER DIRECTOR <u>Thomas Kutis</u>	ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>7-20-59</u>	26. REGISTRAR'S SIGNATURE <u>John O. Murphy, D.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Simon C. Hill* _____

Licensed Embalmer No. *12347* _____

P. O. Address *2706 Hawthorn* _____

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.