

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS NOV 28 1960 **174**

-60-041829  
STATE FILE NUMBER

Registration District No. 5563 Primary Registration District No. 126 Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <b>Iron</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Iron</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Liberty Twp.</b>		Length of stay in 1b <b>7 years</b>	c. CITY OR TOWN <b>Glover</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5 mi. SE of Glover</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5 mi. SE of Glover</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Iva</b> Last <b>Madden</b>			4. DATE OF DEATH Month <b>November</b> Day <b>5,</b> Year <b>1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/24/1888</b>	9. AGE (last birthday) <b>72</b>
				IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>Eddyville, Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Robert Ethridge</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>John Robert Madden</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.	17. INFORMANT Address <b>Mrs Louise Kimes, Overland, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Mycarditis</b>					<b>?</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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)	
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 _____, to _____ and last saw her/him alive on <b>Saturday 11-5-60</b> Death occurred at _____ P _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>P. K. Howell</i> (Degree or title) <b>Coroner</b>			22b. ADDRESS <b>Ironton, Mo.</b>		22c. DATE SIGNED <b>11-9-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/9/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Big Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Glover, Mo.</b>	
24. FUNERAL DIRECTOR <b>White Funeral Home</b> <i>Ansel White</i>	ADDRESS <b>Ironton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-10-60</b>	26. REGISTRAR'S SIGNATURE <i>Mrs Aris Jones</i>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

for by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed A. R. Howell

Licensed Embalmer No. 967

P. O. Address Montgomery

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.