

No. 2
12-45
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X47070

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20466**

FILED JUN 3 1947

Registration District No. **92947**

Primary Registration District No. **4166**

Registrar's No. **16**

1. PLACE OF DEATH:

(a) County **De Kalb**
(b) City or town **Weatherly**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution, write street number or location. (Specify whether)
In this community **live** years, months or days (Specify whether)

3. (a) PRINT FULL NAME **WINNIE M. BRADFORD**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 29 1870**
(Month) (Day) (Year)

8. AGE: Years **77** Months **9** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **De Kalb Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **John J Bradford**

13. Birthplace **Weatherly Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Calvin Jones**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. Clair Garrison**

(b) Address **Wayssville Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 4 47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Weatherly Mo**

18. (a) Signature of funeral director **W. Clair Garrison**

(b) Address **Wayssville Mo**

19. (a) **6-16-47** (Date received local registrar) (b) **W. Garrison** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **De Kalb 32**
(c) City or town **Weatherly Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2nd** year **1947** hour **9** minute **35** A.M.

21. I hereby certify that I attended the deceased from **25** _____, 19**44** to **June 2** _____, 19**47**
that I last saw her alive on **June 2** _____, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic myocarditis**
Due to _____
Due to _____

Other conditions **chronic cholecystitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **939**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **0**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Fred Kullgren** (M. D. or other) **MD**
Address **Uniontown Mo** Date signed **June 4 47**

Duration

Several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....
....., Registered Apprentice, No.....
working under my personal supervision.

Signed

John G. Brown
.....
Licensed Embalmer No. 3933
P. O. Address Waysville, Mo.

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 this body is not embalmed, fact should be so stated above.