

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

JAN 28 1928

43808

1. PLACE OF DEATH

County Sullivan
Township Rock
City Milan Mo

Registration District No. 852
Primary Registration District No. 7576

File No. _____
Registered No. 58
St. _____ Ward _____

2. FULL NAME

George W. Bradshaw

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah A. Maude Bradshaw

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 5 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 8 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Iowa
(STATE OR COUNTRY)

10. NAME OF FATHER Peter Bradshaw

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Maria Dickson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Thomas Bradshaw
(Address) Estherville Iowa

15. FILED 12-16 1928
Ortha Mclary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 1928

17. I HEREBY CERTIFY, That I attended deceased from 12-6-28 19____, to 12-15 19____ & that I last saw him alive on 12-28 19____; and that death occurred, on the date stated above, at 6.30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis
90B
951B (duration) yrs. 1 mos. ds.

CONTRIBUTORY Overcompensation
(SECONDARY) (duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED now
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) Earl Hickson, M. D.

12-15-1928 (Address) Milan Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oakwood Cem Milan Mo DATE OF BURIAL Dec 15 1928

20. UNDERTAKER Ch. Schaefer ADDRESS Milan Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

