

Registration District No. **65**
AUG 11 1939

Primary Registration District No. **4363**

Registrar's No. **92**

1. PLACE OF DEATH: **1**
(a) County **Newton**
(b) City or town **Neosho**
(c) Name of hospital or institution **Reynolds Hospital**
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number and location)
(d) Length of stay in hospital or institution **2 days**
(Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **DONALD ANDREW BRADLEY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan. 9 - 1934**
(Month) (Day) (Year)

8. AGE: Years **5** Months **6** Days **11** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER
12. Name **Carl Bradley**
13. Birthplace **Juneville Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Juneville Weyer**
15. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **June Bradley**
(b) Address **Juneville Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-25-39**
(Month) (Day) (Year)

(c) Place: burial or cremation **Juneville Mo.**

18. (a) Signature of funeral director **Lee O. Carnell**
(b) Address **Juneville Mo 543**

19. (a) **7-28-39** (Date received local registrar) (b) **Wm. H. ...** (Physician's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **McDonald**
(c) City or town **Juneville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **20th** year **1939** hour **6** minute **15** P. M.
21. I hereby certify that I attended the deceased from **July 19** 19**39**, to **July 20**, 19**39** that I last saw him alive on **July 20**, 19**39** and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis from ruptured appendix**
Due to _____
Due to _____

Other conditions **121**
(Include pregnancy within 3 months of death)

Major findings: **Appendiceal Abscess**
Of operations _____
Of autopsy **None**

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? _____

23. Signature **J. P. Reynolds** (M. D. or other) _____
Address **Neosho Mo** Date signed _____
While at work? _____ (Specify type of place)
(e) Means of injury _____

PHYSICIAN
Duration
Underline the cause to which death should be charged statistically

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.