

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.

JUN 10 1939

Registration District No. 122

Primary Registration District No. 3009

1. PLACE OF DEATH:  
(a) County Cape Girardeau Mo  
(b) City or town Cape Girardeau  
(c) Name of hospital or institution South East Mo. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11-27-39  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days  
3. (a) PRINT FULL NAME Mrs Ora Bradshaw  
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 \_\_\_\_\_  
6. (b) Name of husband or wife Charles Bradshaw 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov-6-1888  
(Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ky  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Jeff Maddox  
18. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lemuel Bradshaw  
(b) Address Morehouse Mo

17. (a) removal (b) Date thereof 12-8-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Cemetery, Sibley  
18. (a) Signature of funeral director Walter H. Smith  
(b) Address Dexter Mo

19. (a) 12-8-39 (b) J. M. Thompson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County New Madrid  
(c) City or town Morehouse  
(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 Dec day 8  
year 1939 hour 3 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 1, 1939  
\_\_\_\_\_, 19\_\_\_\_, to Dec 8, 19\_\_\_\_;  
that I last saw her alive on Dec 8, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic coma  
Diabetic neuropathy

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Fractured ball headed (stone)  
(Include pregnancy within 3 months of death)

Major findings: Cholelithiasis & cholecystitis  
Of operations Cholecystectomy  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature A. B. Conrad M.D. (M. D. or other) \_\_\_\_\_  
Address Cape Girardeau Mo (City or town) (County) (State)

**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.....

Virgil H. Helch....., Registered Apprentice No. no  
working under my personal supervision.

Signed Virgil H. Helch.....

Licensed Embalmer No. 4102.....

P. O. Address Defton, 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, above space should be left blank.**

Sup of 42958-57

FILED MAR 4 - 1940

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

S-42958  
~~7495~~  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 603

(b) Township West Primary Registration District No. 4357

(c) City Morehouse (d) Street No. \_\_\_\_\_

(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U.S.A. of foreign birth? \_\_\_\_\_ yrs. mos. ds.

2. PRINT FULL NAME Mrs. Orea Alice Bradshaw

(a) Residence, No. \_\_\_\_\_ (Usual place of abode, if no street address, write county or city) \_\_\_\_\_ (If nonresident, give city or town and State) \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE w

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 26 - 1889

7. AGE YEARS 51 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison, KY

13. NAME Jelly Maddox

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

15. MAIDEN NAME Maggie Maddox

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Lemmi Bradshaw (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Hart cemetery DATE Dec 10, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins Dexter Missouri

20. FILED File 1940 Mrs. J. Parrish Local Registrar.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 8 1939

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 1939, to Dec 8 1939

I last saw her alive on Dec 8 1939. Death is said to have occurred on the date stated above, at 3:15 am.

The principal cause of death and related causes of importance were as follows:

Ruptured Aortic Aneurysm  
(One pressure by stone on aortic duct)  
Pneumonia

Other contributory causes of importance:  
Heart failure  
Pneumonia

Name of operation Cholecystectomy Date of Dec 6, 1939

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) A. B. E. Wood M. D.  
5310 (Address) Cape Girardeau, Mo.

MAKING RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
V. S. No. 2. 50M-9-19-38 I X18603

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.

RECEIVED

District Health Officer No. 2

District File Number 240-661

Date Filed 2/28/40

5-42958

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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.)**

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