DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1940

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 13577

Registrar's No. 3779

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.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Masonic Home Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community 11 years and 16 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 12 (If outside city or town limits, write "RURAL")

(d) Street No. 5351 Delmar Blvd. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Daniel L. Bradshaw 632

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 12th (Day) 1853 (Year)

8. AGE: Years 86 Months 4 Days 13 If less than one day hr. min.

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

10. Usual occupation Grocery business

11. Industry or business

FATHER
12. Name W. N. Bradshaw
13. Birthplace North Carolina (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Leonna Foust
15. Birthplace North Carolina (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fannie Spence

(b) Address 5351 Delmar Blvd. St. Louis, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-27-40 (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) APR 26 1940 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25, year 1940 hour 4. 20 minute P. M. M.

21. I hereby certify that I attended the deceased from January 20, 1936, to April 25 1940 that I last saw him alive on April 25, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Valvular Heart Disease	4 yrs
Due to	
Due to Senility	6 mths
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Alon Lawson (M. D. or other)

Address 508 N. Grand Blvd. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Albert E. Klapp

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.