

No. 2  
4-13-40  
5-1-41

FILED FEB 16 1942

Registration District No. **427**

Primary Registration District No. **4253**

1. PLACE OF DEATH:

(a) County **Johnson**  
(b) City or town **Halden**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Not hospitalized**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1** (Specify whether) **1**  
In this community **Nine years** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson** **51**  
(c) City or town **Halden** (If outside city or town limits, write "RURAL") **0**  
(d) Street No. **Elm Street** (If rural, give location)  
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRENT FULL NAME

**LILLIE MAY BRADSHAW**

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

3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **John Marion Bradshaw** 6. (c) Age of husband or wife if alive **66** years  
7. Birth date of deceased **March 30 1867** (Month) (Day) (Year)

8. AGE: Years **74** Months **9** Days **9** If less than one day hr. min.

9. Birthplace **Missouri County Kansas** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **at home**

12. Name **Charlie Pine**

13. Birthplace **unknown 9** (City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **unknown 9** (City, town, or county) (State or foreign country)

16. (a) Informant **Alonso Lee Bradshaw**

(b) Address **23 1/2 32nd Kansas City, Mo**

17. (a) **Burial** (b) Date thereof **Jan 11 1942** (Month) (Day) (Year)

(c) Place: burial or cremation **Blau, Creek Cemetery**

18. (a) Signature of funeral director **Woodman Funeral Home**

(b) Address **Halden Mo**

19. (a) **Jan 11** (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9th** day **January** year **1942** hour **4:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **Dec 31**, 19**41**, to **Jan 9**, 19**42** that I last saw her alive on **Jan 8**, 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **430**

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

Major findings: Of operations **/** Of autopsy **/**

Duration  
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? **/**

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

23. Signature **Kelly Rawlin** (M. D. or other) Address **Halden Mo** Date signed **1/9/42**

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

MOTHER FATHER

1002

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-13-42

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 Samuel B. Ropp

Licensed Embalmer No. 4044

P. O. Address Holden Md

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.

Registration District No. 427

Primary Registration District No. 4253

Registrar's No. no. 1

1. PLACE OF DEATH:

(a) County Johnson Golden  
(b) City or town Golden  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillee M. Bradshaw

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 30  
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-11-1942 (b) Mrs Frank Martin  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day \_\_\_\_\_ Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

10N  
**RECEIVED**

District Health Officer No. 8,

District File Number .....

Date Filed .....

5-2607

RECEIVED DISTRICT HEALTH OFFICER NO. 8