

FILED AUG 7 1943

Registration District No. 24196

Primary Registration District No. 5-339-5352

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Texas Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sherman, Texas
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas
(c) City or town Texas Rural
(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? 2 yrs.

3. (a) PRINT FULL NAME THOMAS LAWRENCE BRADFORD

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 Married
6. (b) Name of husband or wife Nettie Bradford
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased Oct 10 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 7 5 hr. min.

9. Birthplace Van Buren Co Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Stafford Bradford
13. Birthplace Penn
14. Maiden name Sarah Prall
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ira Bradford
(b) Address Texas Rd

17. (a) Burial (b) Date thereof May 20 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hope well

18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo

19. (a) 6/9/43 (b) Helen R Davis
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1943 hour 7 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan 36th 1943 to May 15th 1943; that I last saw him alive on May 15th 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Simple Heart Failure

Due to Chronic Myocarditis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
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 G J Myers (M. D. or another)
Address Macks Creek Mo Date signed 6/7/43

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

20
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RECEIVED

District Health Officer No. 7.

District File Number

7-43-751

Date Filed

8-6-43

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, fact should be so stated above.