

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29748**

Registrar's No. **8682**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County **ST LOUIS MO**
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ENROUTE TO HOMER ST Phillips
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **4 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **17**
 (c) City or town **ST LOUIS** **921**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2730 STODDARD ST**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **EUGENE BRADSHAW**

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

4. Sex **Male** 5. Color or Race **Co 1** 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **JULY 18 1929**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	14	2	25	hr. _____ min. _____

9. Birthplace **ST LOUIS MO**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Usher**

11. Industry or business **Roosevelt Theater**

12. Name **ALBERT BRADSHAW**

13. Birthplace **GREENVILLE MISS**
 (City, town, or county) (State or foreign country)

14. Maiden name **EMMA PITTS**

15. Birthplace **HOLLY RIDGE MISS**
 (City, town, or county) (State or foreign country)

16. (a) Informant **ALBERT BRADSHAW**

(b) Address **2730 STODDARD ST**

17. (a) **BURIAL** (b) Date thereof **10-1-43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cem**

18. (a) Signature of funeral director **Ellis Funeral Home**
 (b) Address **2820 Stoddard St**

19. (a) **1943** (b) **J. J. Borden**
 (Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **25**
 year **1943** hour **9** minute **40 P.M.**

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

Immediate cause of death **Internal hemorrhage from gunshot wound of chest and other injuries of the hands of one Walter Shotter in front of 810 No. Leffingwell Ave. about 9.35 pm Sept 25 1943**

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

Major findings: Of operations **166**
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **Homicide**
 (b) Date of occurrence **Sept. 25 1943**
 (c) Where did injury occur? **St Louis**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

(Specify type of place) _____
 (Specify means of injury) **Gunshot**

23. Signature **Walter Shotter** (M. D. or other) _____
 Address **St Louis** Date signed **9/27/43**

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

MOTHER FATHER

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 myself

Lonnie Baykins, Registered Apprentice No. _____
working under my personal supervision.

Signed Lonnie Baykins

Licensed Embalmer No. 2946

P. O. Address St Louis 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, fact should be so stated above.