

Registration District No. 322

Primary Registration District No. 3071

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 332 N Porter
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 yr (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. 332 N Porter
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country A

3. (a) PRINT FULL NAME GARNETT BRADSHAW

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

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

6. (b) Name of husband or wife Cora O'Howell Bradshaw 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased may - 19 - 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Saline Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Clayborne Bradshaw
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Murphy
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Mar Cora Bradshaw
(b) Address Slater mo

17. (a) Burial (b) Date thereof 11-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Smith Chapel Cem, Saline Co mo

18. (a) Signature of funeral director Harry Hershberger
(b) Address Marshall mo

19. (a) 11-30-43 (b) Mr. John Giger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30 year 1943 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 1941 to Oct. 30 1943 that I last saw him alive on Oct. 29 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Due to hypertension

Due to 930

Other conditions (Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

Duration
?
2 wks
?

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 W. M. Lerner (M.D. or other)
Address Slater, Mo Date signed 10/30/43

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

MOTHER FATHER

12.11

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-3-45

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.