

FILED SEP 4 1945

Primary Registration District No. 1000

Registrar's No. 905

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
3001 Angelique Street, 1  
(If not in hospital or institution, write street number or location)

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

In this community life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St. Joseph 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 3001 Angelique Street, 7  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Kate Austin Bradshaw

3. (b) If veteran, name war none

3. (c) Social Security No. 488-14-9200

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th  
year 1945 hour 8 minute 50 P.M.

4. Sex female / 5. Color or race white

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

6. (b) Name of husband or wife Ralph Ray Bradshaw

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased December 13 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 17, 1945, to Aug 25, 1945;  
that I last saw her alive on Aug 25, 1945;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>8</u>	<u>12</u>	.....hr. ....min.

Immediate cause of death Cerebral Hemorrhage *few hours*

Due to High tension *hrs*

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation retired cafeteria helper

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

Major findings: Of operations.....

Of autopsy.....

11. Industry or business Sun Mfg. Co.

12. Name John Morris Austin

13. Birthplace De Peyster N. Y.  
(City, town, or county) (State or foreign country)

14. Maiden name Anna E. Nash

15. Birthplace Carlyle Kentucky  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Ralph R. Bradshaw

(b) Address 3001 Angelique Street,

17. (a) burial (b) Date thereof 8/28/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cem. Gower, Mo.

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?

18. (a) Signature of funeral director Hester Bettle & Bauerman

(b) Address 319 So. 10th Street,

19. (a) 8/28/45 (b) Hester Bettle  
(Date received local registrar) (Registrar's signature)

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

23. Signature Dr. M. J. Fillion (M. D. or other) MD  
Address St. Joseph, Mo Date signed 8-27-45

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

MOTHER FATHER

Dr. J. W. Fucon  
Rm. 13 Bldg.

**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 *Frank A. Brown*

Licensed Embalmer No. *710*

P. O. Address *St. Joseph, 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.**