

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27170

State File No. _____
Registrar's No. 176

FILED AUG 24 1945

Registration District No. _____ Primary Registration District No. 3016

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

126
5
4

1. PLACE OF DEATH:

(a) County Calhoun

(b) City or town JEFFERSON CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST MARYS HOSPITAL - 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether)

In this community 3 days
years, months or days

3. (a) PRINT FULL NAME CHRISTINE - BRADSHAW

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race White

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

6. (b) Name of husband or wife LEWIS - BRADSHAW

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased July 9 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63 0 29 - hr. - min.

9. Birthplace COOPER - Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business HOME

MOTHER FATHER

12. Name HENRY - HAMMER -

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

14. Maiden name CHRISTINE - VAN - HOUSER

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

16. (a) Informant Mrs Lewis Bradshaw

(b) Address Edon Mo

17. (a) BURIAL (b) Date thereof MAY - 11 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PIOLET - GROVE - MO

18. (a) Signature of funeral director Keith M. Kaye

(b) Address Edon Mo

19. (a) 8-8-45 (b) Theresa Richter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MILLER Co

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. West Aurora
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1945 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from 8/6
1945 to 8/8 1945

that I last saw her alive on 8/8 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory collapse Duration 1 day

Due to Cholecystitis Hepatitis 2 months

Due to _____

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

Major findings:
Of operations _____

Of autopsy 125 X

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 N. Kanagawa (M. D. or other)

Address 129 E High St Date signed 8/8

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-23-45

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 Keith M. Kayl
Licensed Embalmer No. 3998
P. O. Address Eldon 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.