

FILED JUN 3 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 1177

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution St. Louis County Hospital
(d) Length of stay: In hospital or institution 4 hrs 45 min
In this community 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis Co.
(c) City or town Springton
(d) Street No. 2232 Denny Rd.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME VIRGINIA BRADFORD
3. (b) If veteran, name war none
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 27th year 1946 hour 5 minute 45 P.M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife William Bradford 6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased: (Month) 7 (Day) 13 (Year) _____

21. I hereby certify that I attended the deceased from May 27th (1 P.M.) to May 27th (5 P.M.) 1946 that I last saw her alive on May 27 1946 and that death occurred on the date and hour stated above.

8. AGE: Years 33 Months 4 Days 20 If less than one day hr. _____ min. _____
9. Birthplace St. Louis Missouri

Immediate cause of death.	Duration
<u>Acute Anemia</u>	<u>36 hrs</u>
Due to <u>Ruptured Ectopic Pregnancy</u>	<u>2 days</u>
Due to _____	_____
Other conditions (include pregnancy within 3 months of death)	_____
<u>Egypt Intoxication</u>	<u>1 week</u>

MOTHER FATHER {
12. Name Fred Mueller
13. Birthplace St. Charles Mo.
14. Maiden name Minnie Baker
15. Birthplace St. Louis Mo.
16. (a) Informant William Bradford (husband)
(b) Address 2232 Denny Rd
17. (a) Burial (b) Date thereof May 31st, 46
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.
19. (a) 5-31-46 (b) Wm. Garman

Major findings:
Of operations _____
Of autopsy negative
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? _____
(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 Paul B. Vatterott (M. D. or other) M.D.
Address St. Louis Co. Hosp Date signed 5/28/46

WRITE PLAINLY—USE UNFADING BLACK INK

JUN 28 1949

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 *John P. Buchholz*

Licensed Embalmer No. *1674*

P. O. Address *2223 St. Louis*

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.

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1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Virginia Bradford

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased: Jan (Month) _____ (Day) _____ (Year)

8. AGE: Years 33 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATE FROM

20. DATE OF DEATH: Month May 27
year 1946 hour _____ minute _____ 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 _____

Due to _____

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 Paul R. Wottrott (M. D. or other) M.D.
Date signed _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITING ONLY - USE UNFADING BLACK INK - PLEASE

No delivery. Patient hemorrhaged into peritoneal cavity from ruptured tubal pregnancy. Patient was taking Ergot. on her own having missed ~~her~~ a menstrual period.

BRW

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