

~~SECRET~~ 5555

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

S. No. 2
M-5-43
5-17-39
I, ХЗСВТ

FILED AUG 20 1946
Registration District No. 2

Primary Registration District No. 4437

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Waynesville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Waynesville General 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6hr. 45Min.
(Specify whether
In this community same
years, months or days)

3. (a) PRINT Mary Chloean Bradford
FULL NAME

3. (b) If veteran, name war _____	3. (c) Social Security No. _____
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4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased June 30 1915
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	31	1	9	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12 Name Archie R. Sanders

FATE } 13. Birthplace Unknown Tenn.
(City, town, or county) (State or foreign country)

ER (14. Maiden name Martha Rimmer

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

16. (a) Informant Miss Louise Bradford

(b) : Address : Lake Springs, Mo.

17. (a) Burial (b) Date thereof 8-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakes Springs, Mo.

18. (a) Signature of funeral director Arthur J. Smith

(b) Address Rolla, Mo.

19. (a) 8-17-46 (b) Louise B. W. Clintock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33
(c) City or town Lake Springs 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9th.
year 1946 hour 8:15 minute P.M.

21. I hereby certify that I attended the deceased from 8-8-
1 1946, to 8-9- 1946
that I last saw her alive on August 9 1946
and that death occurred on the date and hour stated above.
Immediate cause of death PNEUMONIA dobor Duration

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)
(c) Means of injury _____ 0

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

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

J. H. Hallen

Licensed Embalmer No.

3643

P. O. Address.

Rolla 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.