

No. 2
 2-43
 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED NOV 12 1947

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

36823
 State File No.
 Registrar's No.

Registration District No. 381

Primary Registration District No. 6179

1. PLACE OF DEATH
 (a) County Sullivan
 (b) City or town Pollock - Rural
 (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 27 yrs years, months or days)

3. (a) PRINT FULL NAME Eliza Christina Bradshaw
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F / 5. Color or race W
 6. (a) Single, widowed, married, divorced widowed
 (b) Name of husband or wife Henry L Bradshaw
 6. (c) Age of husband or wife if alive dead years
 7. Birth date of deceased 2 (Month) 23 (Day) 1870 (Year)

8. AGE: Years 77 Months 7 Days 24 If less than one day hr. _____ min. _____

9. Birthplace Pollock Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer's Wife

11. Industry or business _____

MOTHER FATHER
 12. Name John C Schnelle
 13. Birthplace Monroe Co Ark (City, town, or county) (State or foreign country) 0
 14. Maiden name Rebecca Steele
 15. Birthplace Pike Co Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant Ailie Schnelle
 (b) Address Pollock - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-47 (Month) (Day) (Year)
 (c) Place: burial or cremation Seabee Cem

18. (a) Signature of funeral director Simmus
 (b) Address Milan Mo

19. (a) Nov 3 - 1947 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature) 212

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Sullivan 105
 (c) City or town Pollock - Rural (If outside city or town limits, write "RURAL") 0
 (d) Street No. Jackson Hwy (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 17 year 1947 hour _____ minute 7:10 P.M.
 21. I hereby certify that I attended the deceased from July 18 1947 to Oct 17 1947 that I last saw her alive on Oct 7 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the rt leg + abdomen. Duration _____

Due to Don't know

Due to _____

Other conditions (include pregnancy within 3 months of death) _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations Carcinoma
 Of autopsy 57
 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) _____ (c) Means of injury 2

23. Signature L. G. Simmons (M.D. or other) D.O.

Address Milan Mo Date signed Oct 17

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

RECEIVED
District of Columbia
District File No. 11-47-
Date Filed NOV 11 194

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 Dwight Schaefer
Licensed Embalmer No. 2668
P. O. Address Milan 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Na

Registration District No. 381

Primary Registration District No. 6179

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Rural
(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

Elyza C. Bradshaw

(b) If veteran, name war _____

(c) Social Security No. _____

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

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

7. Birth date of deceased Feb 2 (Month) (Day) (Year)

8. AGE: Years 77 Months 7 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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(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 CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____ Duration _____

On the back of right leg where her heel operated on at

Due to _____

Due to Columbia nyo. Cancer Hospital, last Feb.

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

Major findings: Of operations _____

Of autopsy _____

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 L. Grace Simmons (M., D. or other) Do

Address Milan, Mo. Date signed 2-27-47

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

SUPPLEMENTARY

S-36823