

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9830

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>2561</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17 9			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res; 5130 Washington</u>				d. STREET ADDRESS (If rural, give location) <u>5130 Washington Blvd.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>BLANCHE</u>		b. (Middle) <u>H.</u>		c. (Last) <u>BRADSHAW.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 20, 1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed.</u>		8. DATE OF BIRTH <u>July 24, 1873.</u>			
9. AGE (In years last birthday) <u>75.</u>		IF UNDER 1 YEAR Months <u>7.</u> Days <u>26.</u>		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Clover, Virginia.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John Heidleberg.</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Robert S. Bradshaw.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robt. S. Bradshaw, Jr.; 5130 Washington</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19a. DATE OF OPERATION <u>Oct 25 1948</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of colon with metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Sept 9, 1948</u> , to <u>March 18, 1949</u> , that I last saw the deceased alive on <u>March 18, 1949</u> , and that death occurred at <u>5:45 P.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Samuel B. Grant M.D.</u>				23b. ADDRESS <u>714 N. Taylor Ave</u>		23c. DATE SIGNED <u>March 21 '49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 22, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery; St. Louis, Mo.</u>		24d. LOCATION (City, town, or county) (State) _____			
DATE REC'D BY LOCAL REG. <u>MAR 22 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.R. Lupton & Sons; 7233 Delmar Blvd</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

2561
1952

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Arnold W. Schoene

Signed.....

Student Embalmer

Licensed Embalmer No.

3864

P. O. Address.....

St. Louis, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.