

No. 300  
10-48

FILED NOV 22 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39213

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 2699

1. PLACE OF DEATH a. COUNTY <u>St. Louis.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves</u> <u>CLAYTON</u>	c. LENGTH OF STAY (In this place) <u>59</u> TOWN	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves</u> <u>4597</u>	d. STREET (If rural, give location) ADDRESS <u>711 Cornell</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION. <u>St. Louis, County Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hannah</u> b. (Middle) _____ c. (Last) <u>Bradley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11 7 50</u>		
------------------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------	--	--

5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDDED/DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 22, 1885</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-----------------------------------------	----------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Allentown, Mo. D</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--------------------------------------------------------------------------------------------------------	-----------------------------------------	-------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME <u>Robert Cooper</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Hhempstead</u>	14. NAME OF HUSBAND OR WIFE <u>Edward Bradley</u>
-----------------------------------------	---------------------------------------------------	---------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>nil</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edward Cooper, 711 Cornell</u>	ADDRESS _____
---------------------------------------------------------------------------------------------------------------------	-------------------------------------	---------------------------------------------------------------------	---------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>  <u>?</u>  <u>?</u>  <u>3 3 1 X</u>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------------------------------------------

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION _____	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) (Min.) _____	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 10-7-, 1950, to 11-7-, 1950, that I last saw the deceased alive on 11-7-, 1950, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Richard R. Calk</u>	23b. ADDRESS <u>601 S Brentwood Clayton 5 Mo</u>	23c. DATE SIGNED <u>11-7-50</u>
---------------------------------------------------------	--------------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>11/11/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Court y</u>
---------------------------------------------------------	---------------------------	-----------------------------------------------------------	-------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>11-10-50</u>	REGISTRAR'S SIGNATURE <u>Herbert R Donke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Wade Granberry</u>	ADDRESS <u>4202 Finney a</u>
------------------------------------------	-------------------------------------------------	-----------------------------------------------------------	------------------------------

*Return* Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....

*Melvin E. Green*

Licensed Embalmer No. *4428*

Signed.....  
Student Embalmer

P. O. Address *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.