

FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6019

State File No. ....

318

1003

Registrar's No. .... 1385

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ / _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST LOUIS,</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST LOUIS,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4476 LEE AVE</b>				e. STREET ADDRESS (If rural, give location) <b>3109 4476 LEE AVE</b>			
3. NAME OF DECEASED a. (First) <b>FRANCES</b> (Type or Print)		b. (Middle) <b>E.</b>		c. (Last) <b>BRADLEY</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 14, 1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>APRIL 1, 1874</b>	9. AGE (In years) <b>80</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>BERNARD THEOS</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH HICKS</b>		14. NAME OF HUSBAND OR WIFE <b>GEORGE BRADLEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>GEORGE BRADLEY 4476 LEE AVE</b>			
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.		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</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	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE (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? <b>321X</b>			
22. I hereby certify that I attended the deceased from <b>2-6</b> , 19 <b>53</b> , to <b>2-13</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>2-13</b> , 19 <b>55</b> , and that death occurred at <b>10:20 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>J.R. Allen M.D.</b>				23b. ADDRESS <b>4155 1/2 Newstead</b>		23c. DATE SIGNED <b>2-14-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>2/16/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>	
DATE REC'D BY LOCAL REG. <b>FEB 14 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>STROOT - CARROLL 4600 NATURAL BRIDGE AVE</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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..

Student.....  
Signature of Student Embalmer

Signed *M. W. R. Ruter*

Licensed Embalmer No. *480*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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