

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22874

State File No.

FILED AUG 9 - 1955

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3042 Registrar's No. 220

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>RALLS</u>	
b. CITY OR TOWN <u>HANNIBAL</u>		c. CITY OR TOWN <u>SALINE TOWNSHIP</u>	
c. LENGTH OF STAY (in this place) <u>12 Days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LEVERING HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>MONROE CITY, MO R.F.D. 2</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>ISORA</u>		b. (Middle) <u>BELL</u>	
c. (Last) <u>BRADSHAW</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 29, 1955</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>OCTOBER 15, 1875</u>
9. AGE (In years last birthday) <u>79</u>		10. <input type="checkbox"/> UNDER 1 YEAR Days <u>8</u>	11. <input type="checkbox"/> UNDER 1 MIN. Hours <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>QUIMBLEY, MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ALBERT BALDWIN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HOUGHTALIN</u>	
14. NAME OF HUSBAND OR WIFE <u>OWEN BRADSHAW</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. William Christian Monroe City, Mo R 2</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>Lower Nephron Syndrome</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic cholecystitis Gallstone, intestinal obstruction 1 wk</u>	
19a. DATE OF OPERATION <u>July 25 1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Partial intestinal obstruction from Gallstone in ileum</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. HOW DID INJURY OCCUR? _____
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21g. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>July 17, 1955</u> to <u>July 29, 1955</u> , that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Charles G. Johnson MD</u>		23b. ADDRESS <u>211 No. Main - Monroe City, Mo</u>	23c. DATE SIGNED <u>Aug 1, 1955</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-31, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Judes Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>MONROE CITY, MO</u>
DATE REC'D BY LOCAL REG. <u>Aug 2-1955</u>	REGISTRAR'S SIGNATURE <u>Wm Lucke By McFisher Wilson & Sons</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Lucke By McFisher Wilson & Sons</u> ADDRESS <u>Monroe City Mo</u>	

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

RECEIVED AUG 8 - 1955
MARION CO. HEALTH DEPT.
DATE FILED AUG 8 - 1955

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 *MU*....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Leslie L. Hoop*.....

Licensed Embalmer No. *3017*.....

P. O. Address *Monroe City*.....

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.