

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

59-010117  
 STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 195 Primary Registration District No. Registrar's No. 28-59

60  
 300  
 1-57

1. PLACE OF DEATH a. COUNTY <b>McDonald</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>McDonald</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Noel</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Noel</b> <b>6600</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>at home</b>		Length of stay in lb <b>5 years</b>	d. STREET ADDRESS <b>Rt. 2</b> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Icie Carl Bradshaw</b>			4. DATE OF DEATH Month Day Year <b>March 1 1959</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15 1884</b>
9. AGE (In years last birthday) <b>74</b>		9. AGE (In years last birthday) F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Jamestown, Ky.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas T. Sullivan</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Coffee</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Forrest Bradshaw</b> Address <b>Noel, Mo. Rt. 2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage -</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Investigated By R.M. Humphrey Jr.</b> DUE TO (c) <b>Coroner of McDonald County</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day Day <b>3:00 p.m.</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Physician's Office</b>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Mary G. Bradley Registrar Pineville, Missouri</b>		22b. ADDRESS <b>Mar 24 '59</b>	
22c. DATE SIGNED		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-4-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Butler Creek Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Sulphur Springs, Ark.</b>
24. FUNERAL DIRECTOR <b>Humphrey &amp; Son Noel, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 23, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mary G. Bradley</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

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 *W. M. Humphrey Jr.*

Licensed Embalmer No. *4708*

P. O. Address *Tracy 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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