

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014728

STATE OF MISSOURI  
Registration District No. 2751

FILED MAY 8 1959

Registration District No.

Primary Registration District No.

300  
-57  
34  
35  
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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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bellefontaine Neighbors</b> 4600 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION: <b>Veterans Odm Hosp</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1225 Esquire Dr</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>Z.</b> Last <b>BRADFORD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>16th</b> Year <b>1959</b>
5. SEX <b>male</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>March 30th, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired baggage handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	9. AGE (In years (birthday) IF UNDER 1 YEAR IF UNDER 24 HRS <b>68</b> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>West Point, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>James Bradford</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Malone</b>	14. NAME OF HUSBAND OR WIFE <b>Jewell Ballard</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW I A.S. 3253859</b>		16. SOCIAL SECURITY NO. <b>702-18-7621</b>	17. INFORMANT Address <b>James C. Bradford, 1225 Esquire Dr.</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>Bleeding gastric ulcer</b> DUE TO (b) <b>Ameschole</b> DUE TO (c) <b>540.0K</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. INTERVAL BETWEEN ONSET AND DEATH <b>1</b> WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of Section 18) <b>While under general operation of gastric respiration at Veterans Hospital on March 16 1959.</b>	
20c. TIME OF INJURY Hour <b>3</b> Month, Day, Year <b>16 59</b> a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hosp</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>1:55 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Patrick Taylor Carow</b> (Degree or title)		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>3.18.59.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>3/19/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 18 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D., P.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

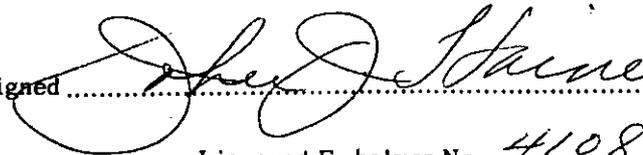
MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4108  
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.