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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37644

Registration District No. 1

Primary Registration District No. 200

Registrar's No. 312

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Clay Township, Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Breashear Mo. R.F.D.#1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 14 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Adair

(c) City or town: Breasher Mo. Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: Breashear, R.F.D.#1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Jesse Harold Bradshaw

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife: ____

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: June (Month) 5 (Day) 1927 (Year)

8. AGE: Years 14 Months 5 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace: Brashear (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: farm boy

11. Industry or business: ____

MOTHER FATHER

12. Name: John Bradshaw

13. Birthplace: Breashear (City, town, or county) Missouri (State or foreign country)

MOTHER

14. Maiden name: Artie Gregery

15. Birthplace: (City, town, or county) Kentuckey (State or foreign country)

16. (a) Informant: John Bradshaw

(b) Address: Brashear Mo. R.F.D. #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Breashear, Cemt.

18. (a) Signature of funeral director: DeRiley

(b) Address: Kirksville, Mo.

19. (a) Nov. 15/41 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7 year 1941 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from April, 1941, to Nov 7, 1941; that I last saw him alive on Nov 7, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple cancer of the bones

Duration

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings: Of operations: ____

Of autopsy: ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): ____

(b) Date of occurrence: ____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: M. F. Kennedy (M. D. or other) M.D.

Address: Kirksville, Mo. Date signed 11/9/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 12-41-2104
Date Filed DEC 3 1941

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~~ ....., Registered Apprentice No. ..... working under my personal supervision.

Signed D E Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

No. 2B
—8-21-41
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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37644

Registration District No. 1 Primary Registration District No. 200 Registrar's No.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jesse H. Bradshaw

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M.

5. Color or race W.

6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 5, (Day) 1925 (Year)

8. AGE: Years 14 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple Cancer of Chone

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

55f