

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34520**

FILED

OCT 28 1943

89

Primary Registration District No. **5-3-284125**

Registrar's No. **369**

1. PLACE OF DEATH:

(a) County **Leasburg, Mo.**

(b) City or town **Leasburg, Mo.**
(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
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Leasburg**

(c) City or town **Leasburg**
(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 **MARY CATHERINE BRADFORD**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **✓** 6. (c) Age of husband or wife if alive **✓** years

7. Birth date of deceased **12 - 25 - 1873**
(Month) (Day) (Year)

8. AGE: **69** Years **9** Months **1** Days If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **David Wilmet Scott**

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

14. Maiden name **Elizabeth Gove**

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

16. (a) Informant **Ether M. Gally**

(b) Address **705 Olive St. Leasburg, Mo**

17. (a) **Remove** (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director **Elbert A. Long**

(b) Address **Leasburg, Mo**

19. (a) **9-25-43** (Date received local registrar) (b) **W. F. Sturm, M.D.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **24th** year **1943** hour **11:45** minute **43** M.

21. I hereby certify that I attended the deceased from **Sept 2** 19**43** to **Sept 24** 19**43** that I last saw her alive on **Sept 23** and that death occurred on the date and hour stated above.

Immediate cause of death **acute endocarditis** Duration

Acute Endocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **918**

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **W. F. Sturm** (M. D.)
Address **Leasburg, Mo** Date signed **9-25-43**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

0.000

RECEIVED

District Health Officer No. 5,

District File Number 1043625

Date Filed 10-19-43

OCT 27 1943

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

Albert E. Long

Licensed Embalmer No. 3504

P. O. Address Bourbon 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.)

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

Registration District No. 89 Primary Registration District No. 4125- Registrar's No. 269

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Leasburg
(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

3. (a) PRINT FULL NAME Mary Catherine Bradford

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec - 23
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 9 (if less than one day) min.

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

10. Usual occupation

11. Industry or business

12. Name

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

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) Sept 24-43 (b) (W. F. J. ...)
(Date received local registrar) (Registrar's signature)

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

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Immediate cause of death

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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(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?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

