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35627

**FILED** APR 24 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. 5731 Registrar's No. 531

**1. PLACE OF DEATH:**  
 (a) County Macon  
 (b) City or town Goldsberry White T.  
(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 Macon  
 (c) City or town Goldsberry  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Elnora Harriett Bradley  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month February day 22  
 year 1946 hour 5 minute 30 A.M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife J. C. Bradley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: November 4 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/19/46 to 2/22/46  
 that I last saw him/her alive on 2/19/46 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>3</u>	<u>18</u>	hr. _____ min.

Immediate cause of death: Cerebral Thrombosis  
 Duration: today

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

Due to: Arterio sclerosis  
 Due to: \_\_\_\_\_

10. Usual occupation: Housekeeping

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

11. Industry or business: \_\_\_\_\_

**MOTHER** { 12. Name Dennis Wright  
 13. Birthplace New York  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Riley  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

**PHYSICIAN**  
 Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Zella Turner  
 (b) Address Goldsberry Mo

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Feb 23 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation Helton  
 18. (a) Signature of funeral director: M. A. McCollum

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

(b) Address South Gifford Mo

23. Signature: D. P. Howard  
(M. D. or other)

19. (a) 4-30-46 (b) Daphne Hewitson  
(Date received local registrar) (Registrar's signature)

Address Macon, Mo Date signed 3/9/46

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

RECEIVED  
District Health Officer No. 10  
District File Number 4-46-898  
Date Filed APR-2-2-1946

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 W. H. McCallum

Licensed Embalmer No. 2052

P. O. Address South Gifford 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 this body is not embalmed, fact should be so stated above.

Registration District No. 201

Primary Registration District No. 5781

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Pual  
(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 Elvora H. Bradley  
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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Nov 4 (Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

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

10. Usual occupation \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) Apr 30, 1946 (b) Daphne Howerton  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 22  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

13832