

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028144

FILED VS JUL 22 1960

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6930

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>				Length of stay in 1b <u>1 WK</u>		c. CITY OR TOWN <u>ARNOLD</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DECONESS Hosp.</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT 2 - BOX 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM J. BRADSHAW</u>				4. DATE OF DEATH Month Day Year <u>JULY - 9 - 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 27 - 1993</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTING</u>		11. BIRTHPLACE (City and state or country) <u>CALIFORNIA</u>		9. AGE (last birthday) <u>67</u>	
13a. FATHER'S NAME <u>JAMES BRADSHAW</u>				13b. MOTHER'S MAIDEN NAME <u>WINIFRED COFFEE</u>		14. NAME OF HUSBAND OR WIFE <u>AGNES BRADSHAW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-28-1459</u>		17. INFORMANT <u>AGNES BRADSHAW ARNOLD M.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver + cirrhosis of liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b)
							DUE TO (c) <u>156.1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input 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 item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6-18-60</u> to <u>7-9-60</u> and last saw ^{her} him alive on <u>7-9-60</u> Death occurred at <u>10:30</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Doctor E Sherman M.D.</u>				22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>7-11-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-12-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE, MO</u>				25. DATE RECD. BY LOCAL REG. <u>JUL 11 1960</u>		26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

71913

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed: *J. A. Miller*

Licensed Embalmer No. *4329*

P. O. Address *St. Louis 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.