

FILED OCT 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34021

4417

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson MO</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>15 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		23 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kansas City Tuberculosis Hosp.</u>				d. STREET ADDRESS (If rural give location) <u>3210 E. 21st St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Shirley</u>			b. (Middle) <u>Ann</u>		c. (Last) <u>Van Wick-</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 1-1920</u>	9. AGE (In years last birthday) <u>28 YRS.</u>	IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research Clinic</u>		11. BIRTHPLACE (State or foreign country) <u>Sedalia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Wm. B. Bradley</u>			13b. MOTHER'S MAIDEN NAME <u>Myrtle Masters-</u>		14. NAME OF HUSBAND OR WIFE <u>Roscoe Van Wick</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>500-09-3585</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Kansas City Tuberculosis Hospital</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Far Advanced Pulmonary Fib.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Post-Operative Shock DO2X</u> <u>24 hrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Far Advanced Pulmonary Fib.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-21</u> , 1949, to <u>10-13</u> , 1949, that I last saw the deceased alive on <u>10-13</u> , 1949, and that death occurred at <u>A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>George K. Landis, M.D.</u> (Degree or title)				23b. ADDRESS <u>K. C. T. B. Hosp.</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT-15-1949</u>		24c. NAME OF CEMETERY OR-CREMATORY <u>MT. MORIAH CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>10-15-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. H. Newcomer 1331-BRUIN GREEN KANSAS CITY, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

**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 .....  
Student Embalmer

Signed *Bernard L. Foran* .....

Licensed Embalmer No. *4250* .....

P. O. Address *N. C. 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.