

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020722

STATE FILE NUMBER

FILED JUL 1 1959

Registration District No. 72

Primary Registration District No. 3013

Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORTH KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MEMORIAL HOSP</b> Length of stay in lb <b>2 DAYS</b>		500' d. STREET ADDRESS (If outside, give location) <b>3830 N. Woodland</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Floyd D. Bradley</b>			4. DATE OF DEATH Month Day Year <b>June 23 1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 18 1915</b>	9. AGE (In years) <b>44</b> (In days) _____	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EARL MILLSAP</b>		11. BIRTHPLACE (City and state or country) <b>KEARNEY, MO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>FRANK BRADLEY</b>		13b. MOTHER'S MAIDEN NAME <b>SOPHIA KERR</b>	
14. NAME OF HUSBAND OR WIFE <b>Alice Bradley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>495-09-3245</b>	
17. INFORMANT <b>Alice Bradley</b>		Address <b>3830 N Woodland</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary arteriosclerosis</b>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 **Jan 1956** to **Jan 1959** and last saw <sup>him</sup> alive on **6-22-59**  
Death occurred at **2 A M** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Robert Hodges MD</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>329 92nd Street West KC Mo</b>	22c. DATE SIGNED <b>6/23/59</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Liberty, Mo.</b>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <b>D.W. Newcomer's</b> ADDRESS <b>N.K.C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-24-59</b>	26. REGISTRAR'S SIGNATURE <b>Marguerite Hudgens</b>
---	--	--

Health, & Welfare Public Service

5. 300 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. **Robert Hodges MD.**

USE ONLY BLACK INK OR RUBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

4740



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 .....  
Signature of Student Embalmer

Signed Glenn H. Hill .....

Licensed Embalmer No. 4586  
P. O. Address R.C. 16, In

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.