

318

1003

4919

=61-018854
STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED JUN 2 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

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		a. STATE	b. COUNTY
c. FULL NAME OF (if not in hospital, give location) HOSPITAL OR INSTITUTION		c. CITY OR TOWN	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		9. AGE (less birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)			
DUE TO (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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
Hour a.m. p.m.		Month, Day, Year	
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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE		22b. ADDRESS	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
ADDRESS		26. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Rowland-Aker Mortuary Service

MAY 25 1961

Loed Smith, M.D.

865

1. PLACE OF DEATH: a. COUNTY: St. Louis MO
 b. CITY: St. Louis MO
 c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Joseph's
 Length of stay in 1b: 2
 2. USUAL RESIDENCE: a. STATE: MO b. COUNTY: St. Louis
 c. CITY OR TOWN: St. Louis Inside Limits: Yes No
 d. STREET ADDRESS: 1812 CURR Reside on Farm: Yes No
 3. NAME OF DECEASED: Mike Gene Bradley
 4. DATE OF DEATH: 7-11-61
 5. SEX: Male
 6. COLOR OR RACE: White
 7. Married Never Married
 Widowed Divorced
 8. DATE OF BIRTH: 7-11-1911
 9. AGE (less birthday): 50
 10a. USUAL OCCUPATION: Steel
 10b. KIND OF BUSINESS OR INDUSTRY: Steel
 11. BIRTHPLACE: Ill
 12. CITIZEN OF WHAT COUNTRY: US
 13a. FATHER'S NAME: Wick
 13b. MOTHER'S MAIDEN NAME: Wick
 14. NAME OF HUSBAND OR WIFE: Wick
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
 16. SOCIAL SECURITY NO.: WIK 06-14910-300
 17. INFORMANT Address: WIK 06-14910-300
 18. CAUSE OF DEATH: PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a): _____
 DUE TO (b): Cirrhosis of Liver
 DUE TO (c): 581.0
 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: Yes No Unknown
 19. WAS AUTOPSY PERFORMED? YES NO
 20a. ACCIDENT SUICIDE HOMICIDE
 20b. DESCRIBE HOW INJURY OCCURRED: _____
 20c. TIME OF INJURY: _____
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 20e. PLACE OF INJURY: _____
 20f. CITY, TOWN, OR LOCATION: _____ COUNTY: _____ STATE: _____
 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
 22a. SIGNATURE: Saunik E. Taylor (Degree or title)
 22b. ADDRESS: 1305 Clark av
 22c. DATE SIGNED: 5/17/61
 23a. BURIAL, CREMATION, REMOVAL (Specify): _____
 23b. DATE: 5-31-61
 23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
 23d. LOCATION (City, town, or county): St. Louis, Mo. (State)
 24. FUNERAL DIRECTOR: _____ ADDRESS: _____
 25. DATE RECD. BY LOCAL REG.: MAY 25 1961
 26. REGISTRAR'S SIGNATURE: Loed Smith, M.D.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.