

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 048

1000

Registrar's No. 1105

63-035136

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 23 1963		1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 41 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2511 S. 15th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND FREDERICK BRADY				4. DATE OF DEATH Month Day Year September 15, 1963							
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/4/1900		9. AGE (last birthday) 63		IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.		11. BIRTHPLACE (City and state or country) Brooklyn, Ind.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME George W. Brady				13b. MOTHER'S MAIDEN NAME Angie Proctor				14. NAME OF HUSBAND OR WIFE Ruby May Brady			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.# 1				16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Ruby Brady, 2511 S. 15th, St. Joseph, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac Dilatation, acute										Minutes	
DUE TO (b) Myocardial infarction										2 wks.	
DUE TO (c) Arteriosclerotic heart disease										?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral embolus due to mural (ventricular) Thrombus										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 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 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 9/2/63 , to 9-15-63 and last saw him alive on 9/15/63 Death occurred at 3:05 p. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) C.A. Potter, Jr., M.D.				22b. ADDRESS Suite 301 Physicians & Surgeons Bldg, St Joseph, Missouri				22c. DATE SIGNED 9/17/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 9/18/1963		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph		STATE Mo.			
24. FUNERAL DIRECTOR Hester-Bowman				ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 20, 1963		26. REGISTRAR'S SIGNATURE Mrs. Clark Handell			

VS 300 Rev. 4/59
1 5117
2 5117
3
4 0
5 1
6
7 1
8 2
9 4200
10
11
12 3-0
13 1-0

DATE AMENDED
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
BY AFFIDAVIT OF
C.A. Potter, Jr., M.D.

USE BLACK INK OR TYPEWRITER RIBBON

SEP 24 1963

DEC 12 1963

Permit issued 9-16-63

211
51109
0 1 1 3
0 1 3

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St. Joseph, 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.