

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 638
 BIRTH NO. _____ REG. DIST. NO. 23 PRIMARY REG. DIST. NO. 5291 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> <u>24</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL, LIBERTY, MO.</u>		c. LENGTH OF STAY (In this place) <u>2 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL, LIBERTY, MO.</u> <u>0</u>		d. STREET ADDRESS (If rural, give location) <u>3 MILES NORTH LIBERTY, MO.</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ISSAC</u> b. (Middle) <u>BRADFORD</u> c. (Last) <u>HENDRIX</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 21, 1949</u>						
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> <u>2</u>	8. DATE OF BIRTH <u>AUG. 12, 1853</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>	IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELL DRILLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>RAY COUNTY, MO.</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>CLARA GREEN</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>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Excelsior</u> ADDRESS <u>Mrs. A. C. Martin Springs, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u>				DUE TO (b) <u>Senility</u>				<u>2 yrs</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <u>IT</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>2 1/2</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) m.		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>Jan</u> , 19 <u>48</u> , to <u>Jan</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Dec</u> , 19 <u>48</u> and that death occurred at <u>2:30 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>W. H. Goodson M.D.</u>				23b. ADDRESS <u>Liberty MO</u>		23c. DATE SIGNED <u>Jan 21/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN. 24, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>		24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO.</u>			
DATE REC'D BY LOCAL REG. <u>Jan. 24, 1949</u>		REGISTRAR'S SIGNATURE <u>Dunnie Haynes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Richard</u>		ADDRESS <u>Excelsior Springs, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-11-49

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 Ludell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.