

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31333

State File No.

BIRTH NO.		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>5935</u>		Registrar's No. <u>296</u>		
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>R.R. #3 Sedalia</u>)		c. LENGTH OF STAY (in this place) <u>58 Yr.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia R.R. #3</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2 1/2 mi. West of Sedalia</u>				d. STREET ADDRESS (If rural, give location) <u>2 1/2 Mi. West of Sedalia</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>			b. (Middle) <u>ASBURY</u>		c. (Last) <u>BRADFORD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 29, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 1, 1863</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bolivar, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dr. John T. Bradford</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Bradford</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 ADDRESS <u>Mrs. Frances Finley, RR #3 Sedalia, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio- Nephritic.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
	- ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension.</u>						<u>5 years.</u>	
	DUE TO (c) <u>Senility.</u>						<u>5 years.</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Blind for many years.</u>						<u>93X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: <u>None, medical treatment only.</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>		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) <u>None.</u>		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>over 5 years</u> , to <u>August 29th, 1949</u> , that I last saw the deceased alive on <u>August 29th 1949</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.								
23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u> (Degree or title)				23b. ADDRESS <u>Sedalia, Missouri.</u>		23c. DATE SIGNED <u>8-30-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-1-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>8-30-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Keckhart</u>		ADDRESS <u>Sedalia Mo</u>		

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 6

District Health Officer No. 8,

District File Number _____

Date Filed 9-22-49

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 Frank S. Coffman Jr.

Licensed Embalmer No. 4559

P. O. Address Sedalia, 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.