

FILED MAY 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018224  
STATE FILE NUMBER  
2339

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</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>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY, Mo.</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>V A HOSPITAL</b>			Length of stay in lb <b>55 years</b>		d. STREET ADDRESS (If outside, give location) <b>3622 HILLHAVEN ROAD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle Last <b>HADLEY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1958</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>May 5, 1895</b>		9. AGE (In years last birthday) <b>63</b>		10. FUNDERS YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Awnings</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Installation</b>			11. BIRTHPLACE (City and state or country) <b>Topeka, Kansas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Phillip Eugene Hadley</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Ellen Reddington</b>				14. NAME OF HUSBAND OR WIFE <b>Letha</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>				16. SOCIAL SECURITY NO. <b>499 09 1335</b>		17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</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>Inanition</b>										INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Bronchogenic carcinoma, left with bilateral adrenal metastasis.</b>												
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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.												
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 <b>March 1, 1958</b> to <b>May 7, 1958</b> Death occurred at <b>6:35</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <b>A. J. Williams, M.D.</b>						22b. ADDRESS <b>VA Hospital, Official Records, KC, Mo.</b>			22c. DATE SIGNED <b>5-7-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5-10-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cem.</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo</b>				
24. FUNERAL DIRECTOR <b>D.W. Newcomers, N.A.C.</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>5-8-58</b>		26. REGISTRAR'S SIGNATURE <b>Irene Marshall</b>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *John Kalsbeck* \_\_\_\_\_

Licensed Embalmer No. *4949*

P. O. Address *No. Kansas City*

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.