

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030182

STATE FILE NUMBER

FILED SEP 11 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8360

S. 300
1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | 8150 CITY OR TOWN <u>Collinsville</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Barnes</u> | | Length of stay in lb <u>2 days</u> | d. STREET ADDRESS (If outside, give location) <u>32 520 Norwood</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WILSON</u> Last <u>BRADLEY</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 7, 1879</u> | | 9. AGE (In years last birthday) <u>78</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u> | 11. BIRTHPLACE (City and state or country) <u>Wichita, Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>George Bradley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Priscilla Jacobs</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mary Ann Valline</u> | |
| 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. <u>Unknown</u> | | 17. INFORMANT <u>P. G. Bradley, 2531 Kenland, St. Louis</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with metastases</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic heart disease with auricular fibrillation</u> | | | | | <u>10 years</u> |
| DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>150 x</u> | | | | | 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 WORK <input type="checkbox"/> 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 _____ to _____ and last saw him/her alive on _____ Death occurred at <u>1:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>FR Bradley</u> M. D. | | 22b. ADDRESS <u>Barnes Hospital</u> | | 22c. DATE SIGNED <u>8/29/58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8/29/58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u> | |
| | | | | 23d. LOCATION (City, town, or county) (State) <u>Collinsville Ill.</u> | |
| 24. FUNERAL DIRECTOR <u>Hubert K. Kasper</u> | | ADDRESS <u>Collinsville, Ill.</u> | | 25. DATE RECD. BY LOCAL REG. <u>AUG 29 58</u> | |
| | | | | 26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, on d</u> S.P. | |

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed Herbert A. Katz

Licensed Embalmer No... 6890

P. O. Address Collinsville, Ill

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.