

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001865  
STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 12

300 4  
1-57

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		c. CITY OR TOWN <b>Warrensburg</b> <i>0512</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <b>Cross Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>405 West Culton</b>	
Length of stay in lb <b>Life</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Anna</b> Last <b>Bradley</b>			4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1883</b>	9. AGE (In years less birthday) <b>75</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Warrensburg, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>W. O. Davis</b>	13b. MOTHER'S MAIDEN NAME <b>Maggie Terherst</b>	14. NAME OF HUSBAND OR WIFE <b>Fred Bradley (Deceased)</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>405<sup>dr</sup> West Culton Lawrence Bradley, Warrensburg, Mo.</b>
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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>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 <b>Warrensburg</b>	COUNTY <b>Mo</b>	STATE
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21. I attended the deceased from <b>Nov. 1958</b> , to <b>Jan. 22 1959</b> and last saw <sup>her</sup> him alive on <b>1-20-59</b> Death occurred at <b>145 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Thee Cooper M.D.</b> (Degree or title)	22b. ADDRESS <b>Warrensburg Mo</b>	22c. DATE SIGNED <b>1-22-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>23 Jan 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Warrensburg, Missouri</b>
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24. EMBLEMA ADDRESS <b>Sweeney-Phillips, Warrensburg, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 23, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Savannah Cretchfield</b>
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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.

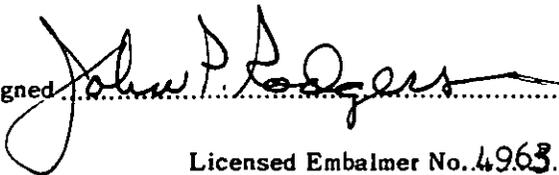
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

6961 0 8

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  .....

Licensed Embalmer No. 4963.....  
P. O. Address Warrensburg, Miss

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.