

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-035962**

FILED VS. SEP. 28 1960

318

Primary Registration District No.

1003

Registrar's No.

9171

STATE FILE NUMBER

INDEXED

DOCUMENT

<b>1. PLACE OF DEATH</b> a. COUNTY				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>MO</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3227 LUCAS AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MAGGIE</b> Middle <b>NMN</b> Last <b>BRADLEY</b>				<b>4. DATE OF DEATH</b> Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>1960</b>				
<b>5. SEX</b> <b>FEMAL</b>	<b>6. COLOR OR RACE</b> <b>NEGRO</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-5-1910</b>	<b>9. AGE</b> (last birthday) <b>49</b>	IF UNDER 1 YEAR Months      Days	IF UNDER 24 HR Hours      Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LAUNDRY WORKER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>KENTUCKY</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		
<b>13a. FATHER'S NAME</b> <b>WILL BRADLEY</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>JOSIE LAST NAME UNKNOWN</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>NONE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <b>SARAH MCCRACKEN FRIEND</b> <b>3227 LUCAS AVE</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>12-24 HOURS</b>		
IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>						<b>4-5 YEARS</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
DUE TO (c) _____						<b>420.0</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. / p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY      STATE					
<b>21. I attended the deceased from</b> <b>SEPT. 28, 1955</b> to <b>SEPT. 14, 1960</b> and last saw her/him alive on <b>SEPT. 14, 1960</b> Death occurred at <b>5:45 A.M.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <i>F. R. Bradley</i> <b>F. R. BRADLEY, M. D.</b>				<b>22b. ADDRESS</b> <b>BARNES HOSPITAL</b>		<b>22c. DATE SIGNED</b> <b>9/15/60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE</b> <b>9-19-1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>WASHINGTON PARK CEMETERY</b>		<b>23d. LOCATION</b> (City, town, or county)      (State) <b>55.00 BROWN ROAD</b> <b>LO</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>E. J. GOLDEN</b> <b>3404 DELMAR BLVD,</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 16 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Loan Smith M.D.</i>			

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Leroy G. [Signature]*

Licensed Embalmer No. 4523

P. O. Address 4251 9

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.