

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

5089 -51-036794
STATE FILE NUMBER

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

FILED OCT 27 1961

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|--|--|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb 3 weeks | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Haven Manor Nursing Home | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3161 Cleveland | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM PETER BRADLEY | | | | 4. DATE OF DEATH Month Day Year Oct. 12, 1961 | | | |
| 5. SEX male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Apr. 23, 1875 | |
| 9. AGE (last birthday) 86 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Clerk (Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Rock Island R.R. Leesville, Mo. | | 11. BIRTHPLACE (City and state or country) U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY | | | | | | | |
| 13a. FATHER'S NAME William S. Bradley | | | 13b. MOTHER'S MAIDEN NAME Zorilda Jane Bradley | | | 13. NAME OF HUSBAND OR WIFE Roberta M. Bradley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mrs. Roberta M. Bradley | | Address 3161 Cleveland Kansas City, Ka. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____ 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 type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | |
| 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.) | | | |
| 20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year | | | | | | | |
| 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 | | COUNTY STATE | |
| 21. I attended the deceased from Oct 10, 1961 to Oct 12, 1961 and last saw him alive on Oct 12, 1961 Death occurred at 1:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Otto H. Thael M.D. | | | | 22b. ADDRESS 4301 Main St. KCMo | | 22c. DATE SIGNED 10-13-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Oct. 14, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Highland Park Cem. | | 23d. LOCATION (City, town, or county) (State) Kansas City, Kansas | |
| 24. FUNERAL DIRECTOR Werner Mortuary | | | | ADDRESS K.C.K. 10-13-61 | | 25. DATE RECD. BY LOCAL REG. 10-13-61 | |
| 26. REGISTRAR'S SIGNATURE Keith A. Long | | | | | | | |

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

OTTO H. THAEL M.D.

BY AFFIDAVIT OF

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 Donald J. Weiner

Licensed Embalmer No. 5007

P. O. Address Kansas City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.