

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

30291

**1. PLACE OF DEATH**

County..... Jackson ..... Registration District No.....  
 Township..... Kansas City Mo ..... Primary Registration District No.....  
 City..... Research Hosp ..... Research Hospital ..... St. .... (Ward)

File No.....  
 Registered No. 3796  
 St. .... (Ward)

**2. FULL NAME**

Baby Boy Bresnahan

(a) Residence. No. Mt Washington Mo .St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-4-27

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
33 min.

8. OCCUPATION OF DECEASED None  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City Mo  
 (STATE OR COUNTRY) Research Hosp

10. NAME OF FATHER Thomas F. Bresnahan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Brookfield Mo  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Myrtle Miffline  
 (STATE OR COUNTRY) Missouri

14. INFORMANT Thomas F. Bresnahan  
 (Address) 308 Overton Ave

15. FILED 10-8-27 1927 M.M. Crowe REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-4th, 1927

17. I HEREBY CERTIFY That I attended deceased from 10-11-27, 1927, to 10-14-27, 1927 that I last saw him alive on 10-14-27, and that death occurred, on the date stated above, at 1:00 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Premature Birth  
159 (7 months)  
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 16!A  
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ophysical

(Signed) Signe Larson M. D.  
10/5/27 (Address) 531 Argyle

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forster Receiving Vault DATE OF BURIAL Oct. 5 1927

20. UNDERTAKER Mrs C. L. Forster ADDRESS KC Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Engine Room  
Carpenter  
Carpenter