

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

Do not use this space.

15158 14891

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... File No.
 City St. Louis (No. City Hospital # 2) Registered No. 4083
 (Ward)

2. FULL NAME

Robert Bradley
 (a) Residence. No. 4-3031 (Usual place of abode) (St. W Ward.)
 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 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 Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
<u>abt.</u>	<u>51</u>	<u>?</u>	<u>?</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamster
 (b) General nature of industry, business, or establishment in which employed (or employee).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Iowa

PARENTS	10. NAME OF FATHER <u>Robert Bradley</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Ohio</u>
	12. MAIDEN NAME OF MOTHER <u>Jennie Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Ohio</u>

14. INFORMANT Anna F. Woodard (Address) City Hospital # 2

15. FILED APR 14 1928 Mar. A. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7, 1928

17. I HEREBY CERTIFY That I attended deceased from 4/6, 1928, to 4/7, 1928 that I last saw him alive on 4/7, 1928, and that death occurred, on the date stated above, at 7:45 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
10 d
 about 10/10 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED not known
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) R. B. Hance, M. D. (Address) City Hospital # 2

*State the DISEASE CAUSING DEATH, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Father Dickerson DATE OF BURIAL April 14 1928

20. UNDERTAKER A. F. Walton ADDRESS 2701 St. Louis

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.

