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

Do not use this space.

33814
4506

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Jackson — Registration District No. .....

Township: Raw — Primary Registration District No. .....

City: Kansas City (No. St Luke's Hosp. .....St. .....Ward)

2. FULL NAME: Infant Bradfield

(a) Residence. No. 4429 Montgall St., 7 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 26-1928

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, 8 hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER: J. D. Bradfield

11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ohio

12. MAIDEN NAME OF MOTHER: Isabella Stoup

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Kansas

14. INFORMANT: Mr. J. D. Bradfield
(Address): 4429 Montgall

15. FILED: 10/27, 1928 M M Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 26 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1928, 19..., to Oct 26, 1928 that I last saw he alive on Oct 26, 9:00 P., 19 28, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
16 hrs P

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Premature Delivery

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 16 hrs
IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

Oct 27, 1928 (Signed) Ralph Kilvert M. D
(Address) 1012 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: Forest Hill

DATE OF BURIAL: 10/27 1928

20. UNDERTAKER: R. V. Lindsey & Sons

ADDRESS: Kansas City, 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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD