AUG 26 1930

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

Do not use this space.

25640

1. PLACE OF DEATH
County Sullivan — Registration District No. 848 — File No. 9
Township Buchanan — Primary Registration District No. 6123 — Registered No. 34
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ida Bradford — Bradford
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-4-1868

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
62	0	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Henry Shaver
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Mary Williams
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo

14. INFORMANT Mrs Mont Murphy
(Address) Green City Mo

15. FILED 7/28 1930 W Parsons REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-26 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-14, 1930, to 7-26, 1930 that I last saw her alive on 6-14, 1930 and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis Caused by Hemorage of Brain
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 74 W
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Ross H Shepler, M. D.
, 19 (Address) Green City Mo

*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	DATE OF BURIAL
Hawkeye	July 28 1930
20. UNDERTAKER	ADDRESS
Glenn E. Kent	Green City Mo