

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

8565

STATE FILE NUMBER **1276**

**FILED APR 2 - 1957**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b> Length of stay in lb <b>0 50 yrs.</b>	
Inside Limits OR TOWN <b>Kansas City</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits OR TOWN <b>Kansas City</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>6530 Charlotte</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>BOBBIE</b> Middle _____ Last <b>BRADFIELD</b>			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>18</b> Year <b>1957</b>				
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> Nov. 16, 1904	<b>9. AGE</b> (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Liberty, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Louie Afton Bradfield</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Molly L. Taylor</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> <b>500-22-0159</b>		<b>17. INFORMANT</b> Mrs. Helen Foster		Address Kansas City Mo.	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyleonephritis, Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>6000</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			

<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m.		Month _____ Day _____ Year _____					
<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____	
<b>21. I attended the deceased from</b> <u>3-15-57</u> to <u>3-19-57</u> and last saw her <sup>alive</sup> on <u>3-19-57</u> Death occurred at <u>9:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>M. Donald McFarland M.D.</b>				<b>22b. ADDRESS</b> <b>315 Nichols Rd</b>		<b>22c. DATE SIGNED</b> <b>3-19-57</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>3/20/1957</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>White Chapel</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City, Missouri</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>stine &amp; McClure - Kansas City, Missouri</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>3-19-57</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Neva Marshall</i>		

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 M. Donald McFarland

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 *Elmo D. Lipscomb* .....  
Licensed Embalmer No. 481

P. O. Address *San Francisco* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.