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

Do not use this space.

29917-C

1. PLACE OF DEATH
County: Worth
Registration District No. 903
File No.
Township: Fletchall
Primary Registration District No. 8212
Registered No. 20
City: Grant City (No. ... St. ... Ward)

2. FULL NAME Ida Alice Bradley

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

Length of residence in city or town where death occurred 1 yrs. 6 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)
F	W	Married

5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of: Henry Bradley

6. DATE OF BIRTH (month, day and year): Sept 7, 1888

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	40	9	23	

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): Don't know
(State or country): Nebraska

PARENTS
10. NAME OF FATHER: Sidney Harper
11. BIRTHPLACE OF FATHER (city or town): Don't know
(State or country): Indiana
12. MAIDEN NAME OF MOTHER: Cora Hiatt
13. BIRTHPLACE OF MOTHER (city or town): Don't know
(State or country): North Carolina

14. INFORMANT: Henry Bradley
(Address): Blockton Iowa

15. FILED 9/3/1929 John Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year): Aug 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Aug 30, 1929
that I last saw her alive on Aug 30, 1929, and that death occurred, on the date stated above, at 9:30 P.m.

THE CAUSE OF DEATH* was as follows:
Fracture of base of skull
Injuries [illegible] out of car
Jumped out of automobile
lighting on head few minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): fell from automobile on head
(duration) yrs. mos. ds.

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? Physical findings
(Signed) J. Rose, M.D.
, 19 (Address) Grant 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
Isadora Cemetery	9/2 1929

20. UNDERTAKER	ADDRESS
H. O. Mumma	Blockton Iowa

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County Worth — Registration District No. 903 — File No.
Township Fleetehall — Primary Registration District No. 6212 — Registered No. 20
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ida Alice Bradley

(a) Residence. No. ..... 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. ..... 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)
F	W	M

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

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

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

8. OCCUPATION OF DECEASED
(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) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 11/10 19 29 John Summers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture of base of Skull
Probable Cerebral Hemorrhage
(duration) .....yrs.....mos.....ds.
CONTRIBUTORY (SECONDARY) Fell from Automobile
(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) ....., M. D.
....., 19..... (Address)

*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 19
20. UNDE...	ADDRESS

SUPPLEMENTARY

S-299171