

FILED NOV 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37135
4535
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION 915 East 84th St.		d. STREET ADDRESS (If rural, give location) 915 East 84th St.	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) McComb c. (Last) Bradfield			4. DATE OF DEATH (Month) (Day) (Year) Oct. 22 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-23-1878	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Abstract Examiner		10b. KIND OF BUSINESS OR INDUSTRY Abstract		11. BIRTHPLACE (State or foreign country) Lebanon Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Geo. W. Bradfield	13b. MOTHER'S MAIDEN NAME Mary Jane Craig	14. NAME OF HUSBAND OR WIFE Emma J. Bradfield
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY (If yes, give year or dates of service) 487-07-5810	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Emma J. Bradfield, Kansas City, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Deputy Coroner	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE A.E. Upsher	(Degree or title) MD	23b. ADDRESS 2850 Main	23c. DATE SIGNED 10/22/49
24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 10-25-1949	24c. NAME OF CEMETERY OR CREMATORY Lebanon	24d. LOCATION (City, town, or county) (State) Lebanon, Missouri

DATE REC'D BY LOCAL REG. 10-24-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS N. B. Longford Leis Summit
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed.....
Student Embalmer

Signed W. B. Langford
Licensed Embalmer No. 3832
P. O. Address Lees Summit

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.