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

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

PLACE OF DEATH

County: Pettis

Township: _____ or Village: _____ or City: Sedalia (NO. _____ St.: _____ Ward)

Registration District No. 668 — File No. 9529

Primary Registration District No. 3032 — Registered No. 59

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Theodosia Ann Bridges

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb. (Month) 4 (Day), 1859 (Year)

AGE: 55 yrs. — mos. 26 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Henry Co. Mo.

PARENTS
NAME OF FATHER: John L. Bridges.
BIRTHPLACE OF FATHER (City or town, State or foreign country): S. Carolina.
MAIDEN NAME OF MOTHER: Martha Rudderford.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Bridges.
(ADDRESS) 14th & Harrison.

Filed March 2 1914. H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

DATE OF DEATH: March (Month) 2 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 1, 1914, to March 1, 1914, that I last saw her alive on Mar 1, 1914, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:
morphinism
87B
76B
153B (Duration) 1 yr. — mos. — ds.

Contributory (SECONDARY) Bed sore & paralysis agitans
Bed sore & mg. Paralysis agitans 30 years (Duration) yrs. mos. ds.

(Signed) Chas Spurrier M. D.
March 2 1914 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Crown Hill cemetery — DATE OF BURIAL: Mar 4 1914

UNDERTAKER: McLaughlin Bros. — ADDRESS: Sedalia Mo.

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

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.

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS