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

PLACE OF DEATH

County Worth

Township Middlefork, or Village or City ~~Worth~~ (NO. ____ St.: ____ Ward)

Registration District No. 1112 — File No. 5182

Primary Registration District No. 6213 — Registered No. ____

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

FULL NAME Abigil Bridges

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

MARGIN RESERVED FOR BINDING

V. S. No. 2.

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widowed

DATE OF BIRTH: Oct 13 (Month), (Day), 1892 (Year)

AGE: 86 yrs. 2 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None ~~Housewife~~
(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Indiana

PARENTS

NAME OF FATHER: John Adamson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

MAIDEN NAME OF MOTHER: Fanny Kerr

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) "

(ADDRESS) Worth Mo.

Filed Jan 3, 1916 W. F. Barnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 26 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 21, 1915, to Dec 26, 1915, that I last saw her alive on Dec 26, 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Acute Indigestion

11A (Duration) ____ yrs. ____ mos. 6 ds.

10A Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O. P. M. Miller M. D.

Dec 27, 1915 (Address) Grant City 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: Shiloh Cemetry

DATE OF BURIAL: Dec 28, 1915

UNDERTAKER: Lester Pettijohn

ADDRESS: Worth Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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 HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Worth

Township Middlefork, or Village ____ or City Worth (No. ____) Registration District No. ____ File No. ____

Primary Registration District No. ____ Registered No. ____

St.; ____ Ward) [If death occurred hospital or institu give its NAME ins of street and number

FULL NAME Abigil Bridg[illegible]

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)
Female	White	widowed

DATE OF BIRTH: Oct 13 (Month) (Day), 1829 (Year)

AGE: 86 yrs. 2 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): "

BIRTHPLACE (City or town, State or foreign country): Christian Co

PARENTS

NAME OF FATHER: [illegible]

BIRTHPLACE OF FATHER (City or town, State or foreign country): [illegible]

MAIDEN NAME OF MOTHER: Fanny Kean

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(ADDRESS) Worth Mo.

Filed ____, 191__, ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 26 (Month) (Day), 191[illegible] (Yea

I HEREBY CERTIFY, that I attended deceased fr
Dec 23, 191[illegible], to Dec 26, 191[illegible]
that I last saw h[illegible] alive on Dec 26, 191[illegible]
and that death occurred, on the date stated above, at 8 P
The CAUSE OF DEATH* was as follows:

La Grippe
Bronchial pneumonia
a[illegible] Cardiac [illegible]

(Duration) ____ yrs. ____ mos. 6 d

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ d

(Signed) [illegible] M. D
Dec 28, 191[illegible] (Address) Worth Mo.

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

LENGTH OF RESIDENCE (For Hospitals Institutions, Transients, o 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
Shiloh Cemetery	Dec 28, 191[illegible]
UNDERTAKER	**ADDRESS**
Lester P[illegible]	Worth