

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

Do not use this space.

24232

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. St Lukes Hosp)

File No. _____
 Registered No. 24232
 St. _____ Ward _____

2. FULL NAME

Miss Ada Bridges
 (a) Residence No. 3323 - Campbell 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. 6 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 15 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
63 | 8 | 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Franklin Co. Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Robert Bridges

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

12. MAIDEN NAME OF MOTHER Rebecca Caldwell

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

14. INFORMANT Mrs. Cora Goode
 (Address) 3323 Campbell St

15. FILED 8/1 27 1927 M.M. Crave
 REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 1927

17. I HEREBY CERTIFY, That I attended deceased from _____
Nov 20 1926 to Aug 1 1927
 that I last saw him _____ alive on Aug 1 1927, and that death occurred, on the date stated above, at 1:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sister adenoma
type
local unknown
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) none
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 6862
 IF NOT AT PLACE OF DEATH: _____

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____ July 1 1927
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Thyroidectomy
 (Signed) _____, M. D.
8-1 1927 (Address) 5500 Olive St Kansas City

*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 Slater Mo. DATE OF BURIAL Aug 3 1927

20. UNDERTAKER Mrs. C. L. Forster ADDRESS 918 Brooklyn

WHY CRIMINAL, WITH UNFADING INK---THIS IS A PERMANENT RECORD

H. 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.

401 - Westover Bl

3:30 to 4 pm