

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

Do not use this space.

14531

1. PLACE OF DEATH
 County St. Louis Registration District No. 791
 Township St. Louis Primary Registration District No. 1003
 City St. Louis (No. 5800) W. 1804 Park Registered No. 3879
 St. _____ Ward _____

2. FULL NAME Minnie Bridges
 (a) Residence, No. _____ St. 13 Ward _____
 (Usual place of abode) _____
 Length of residence in city or town where death occurred _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 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) Oct 11 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 6 7

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm. Bridges
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Avery Harmon
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind
 (STATE OR COUNTRY)

14. INFORMANT Paul Bridges - (niece)
 (Address) 1804 1/2 Park Ave

15. FILED APR 28 1930 W. J. Starnes
 REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18 19 30

17. I HEREBY CERTIFY, That I attended deceased from 4-1 1930, to 4-18 1930 that I last saw her alive on 4-17 1930, and that death occurred, on the date stated above, at 2:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 910
 _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF BIRTH _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) W. J. Starnes, M. D.
4-18 1930 (Address) 5600 Arsenal

*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
Bark Lawn Cemetery Apr 22 1930

20. UNDERTAKER W. J. Starnes ADDRESS 11631 Mission

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.

RECORD

