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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

Do not use this space.

13482

1. PLACE OF DEATH  
County Jackson Registration District No. 399  
Township \_\_\_\_\_ Primary Registration District No. 1008  
City Kansas City No. 1008 St. \_\_\_\_\_ Ward \_\_\_\_\_  
2. FULL NAME Baby Bridges  
(a) Residence, No. 4032 Bellfontaine 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. \_\_\_\_\_  
Registered No. 1818  
St. \_\_\_\_\_ Ward \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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) 4-22-33  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min. 12 hrs  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.  
13. NAME Ferrill Summers  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
15. MAIDEN NAME Lucille Bridges  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.C. Mo.  
17. INFORMANT Lucille Bridges  
(ADDRESS) 4032 Bellfontaine  
18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds DATE 3-24-33  
19. UNDERTAKER Quirk & Tobin  
(ADDRESS) \_\_\_\_\_  
20. FILED Apr 25 1933 M. M. Brome  
Asst Registrar

MEDICAL CERTIFICATE OF DEATH

1  
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-22-1933  
22. I HEREBY CERTIFY, That I attended deceased from 4-22-, 1933, to 4-22-1933  
I last saw her alive on 4-22-, 1933. Death is said to have occurred on the date stated above, at 9:20 p.m.  
The principal cause of death and related causes of importance were as follows:  
P159  
Prematurity  
Other contributory causes of importance: \_\_\_\_\_  
8 159  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) H. L. Sawyer, M. D.  
(Address) Mercy Hosp.  
13, Kansas

