DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30838

1939 OCT 14 Registration District No. 791

Primary Registration District No.

Registrar's No. 7901

1. PLACE OF DEATH: 1003

(a) County 1

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No. 4934 McPherson Avee
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Roscoe /C. Bridges. 632

3. (b) If veteran, name war World War

3. (c) Social Security No. Unk

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Elra Bridges

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased June 7, 1881.
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
58	3	4	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation W. P. A. Worker 0

11. Industry or business City Water Dept 9

MOTHER FATHER

12. Name Unknown Bridges

13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) Unknonw (State or foreign country)

16. (a) Informant's own signature Mrs. Nellie Johnson

(b) Address Chicago, Illinois.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/13/39 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.,

19. (a) SEP 13 1939 (Date received local registrar) (b) J. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 year 1939 hour 8 minute 25 A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage; (Apoplexy) — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Alfred Perry (M. D. or other)

Address Deceased Date signed 9-13-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 x19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Albert W. Hoppe

Licensed Embalmer No. 1861

P. O. Address 4700 Washing

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.