

X23159

JAN 25 1946
Registration District No. **284**

Primary Registration District No. **5404B**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Holcomb, Mo. R. 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Holcomb, Mo. R. 1 (Tricked)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Clarise Cordelia Bridges

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife B. F. Bridges 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased May 10 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Dunklin County (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thornberg

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

14. Maiden name Susan Ellsworth

15. Birthplace Stoddard County (City, town, or county) (State or foreign country)

16. (a) Informant B. F. Bridges

(b) Address Holcomb, Mo. R. 1 (Tricked)

17. (a) Burial (b) Date thereof Dec. 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pipe City

18. (a) Signature of funeral director Louisa P. Pennington

(b) Address Cassell Mo. A. F. W.

19. (a) 1-10-40 (b) J. Anderson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8 year 1940 hour 1:30 minute _____ M.

21. I hereby certify that I attended the deceased from Oct 15 1940 to Dec 8 1940 that I last saw her alive on Dec 6 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer uterus

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature M. J. Cochran (M. D. or other) 3
Address Holcomb Date signed _____

Duration Unknown
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

5

RECEIVED

District Health Officer No. 2

District File Number 141-119

Date Filed 1/24/41

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 ⁷²⁰.....

..... Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42418

Registration District No. 286

Primary Registration District No. 5404B

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Holcomb, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Clarise Cordelia Bridge

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

FATHER { 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace Standard county (City, town, or county) Missouri U.S.A. (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

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

DEATH CERTIFICATION

20. DATE OF DEATH: Month Dec day 8 year 1940 hour _____ minute _____ 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 _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature John E. Cochran (M. D. or other) _____

Address Holcomb, Mo. Date signed _____

