

FILED FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1078**
Registrar's No. **38**

Registration District No. **399** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Resnick
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 6 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cass
(c) City or town Peculiar
(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 Mary Bridgforth
8. (b) If veteran, name war No 8. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 11
year 1941 hour 10 minute 15 A. M.
21. I hereby certify that I attended the deceased from 12-29-1940
1940, to 1-4-41, 1941;
that I last saw her alive on 1-4-41, 1941;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles Bridgforth
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased: April 28, 1884
(Month) (Day) (Year)

Immediate cause of death:
Septicemia
Staph. aureus (blood stream)
Due to Infection lower leg
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

8. AGE: Years 56 Months 8 Days 8
If less than one day hr. _____ min. _____

9. Birthplace: Richmond, Va. (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: _____
12. Name: W. J. Moses
13. Birthplace: Richmond, Va. (City, town, or county) (State or foreign country)
14. Maiden name: Amanda Wilson
15. Birthplace: Richmond, Va. (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
16. (a) Informant: Charles Bridgforth
(b) Address: Peculiar, Mo.
17. (a) Burial (b) Date thereof: 1-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Buried Peculiar, Mo.
18. (a) Signature of funeral director: Paul Brownfield
(b) Address: Pleasant Hill, Mo.
19. (a) Jan 5, 1941 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence: 12-27-40
(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 Walter Hillman (M., D. or other)
Address: 1132 East Bell Date signed: 1-4-41

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

24 a

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10787

Registrar's No. 38-7

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

(a) County Jackson N.C.
(b) City or town Research
(c) Name of hospital or institution:
Research
(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)

3. (a) PRINT FULL NAME

Mary Bindzforth

3. (b) If veteran, name war..... (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..... year

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

8. AGE: Years Months Days If less than one day
56

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

10. Usual occupation.....

11. Industry or business Simple

12. Name Lowe
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 115/41

19. (a) (Date received local registrar) (b) M. M. Brown (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4-41
year..... hour..... minute..... M.

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

Immediate cause of death.....

Rest. cerebra
staph aureus (blood stream)

Due to Infectious lower lip

Due to Simple Cause unknown

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

Major findings: Of operations.....

Of autopsy..... 157.40'
24a

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

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

(b) Date of occurrence 12-27-40

(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..... (M. D. or other).....
Address..... Date signed.....

TEMPORARILY SUPPLEMENTED

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

S-1078