DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1942

Registration District No. 93

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30204

Primary Registration District No. 5336

Registrar's No. 38

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 Mi. North of Greenfield /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dade 29
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SOPHIA BRIDGEWATER
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 Widowed
6. (b) Name of husband or wife Thomas Bridgewater
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October (Month) (unknown) (Day) 1855 (Year)

8. AGE: Years 86 | Months 9 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio / (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Kousher
13. Birthplace (City, town, or county) Ohio / (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Nanny Martin
(b) Address Greenfield Star RR 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Grove Cem.
18. (a) Signature of funeral director Ward Funeral Home
(b) Address Greenfield, Mo. By Rollins Knott
19. (a) Sept 25-42 (Date received local registrar) (b) Phyllis Lack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23 year 1942 hour 3 minute 00 A.M.
21. I hereby certify that I attended the deceased from Aug. 1, 1942 to Sept 10 - 1942 that I last saw her alive on 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio Vascular disease	Don't Know
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Fractured hip	

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) 929 V
(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 M. D. Combs (M. D. or other)
Address Lockwood Mo Date signed 9-23-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1042-1439
Date Filed OCT 6 1942

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 Rollins Knott
Licensed Embalmer No. 3685
P. O. Address Greenfield, Ma

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, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. 30204

Registration District No. 93 | Primary Registration District No. 5336 | Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Rural
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sophia Bridgewater

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 86 | Months 9 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

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

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1942 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.

	Duration
Immediate cause of death Cardio-Vascular disease	4 hr.
Due to	
Due to	
Other conditions Fracture Hip (Include pregnancy within 3 months of death)	1

Major findings:
Of operations 18a
Of autopsy 18

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) Accident
(b) Date of occurrence Aug. 2 1941
(c) Where did injury occur? At her home (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? On farm
(Specify type of place)
While at work? no (c) Means of injury fell on floor

23. Signature H. D. Combs (M. D. or other)
Address Lockwood Mo Date signed 10-21-42