

S. No. 2
4-8-43
5-17-39
PI X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29153**
Registrar's No. **8092**

FILED SEP 30 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Bros Hosp
(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 Mo (b) County _____
(c) City or town 1126 Talmage Ave
(If outside city or town limits, write "RURAL")
(d) Street No. St. Louis
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Oscar O Bridger
(b) If veteran, name war No
(c) Social Security No. 492 16 9701

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 18
year 1944 hour 6.20 PM minute _____ M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Aug 1 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6 1944 to 9-18 1944
that I last saw him alive on 9-18 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
62 1 17 hr. _____ min.

Immediate cause of death Acute Coronary Thrombosis Duration 3 day
Due to Uncontrolled Fibrillation 3 mo

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

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

10. Usual occupation Maintenance Man
11. Industry or business Mines Manft Co

Major findings:
Of operations no
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
12. Name George Bridger
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Lula Bridger
(b) Address 1126 Talmage Ave
17. (a) Burial (b) Date thereof. (9 21 44)
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
(c) Accident, suicide, or homicide (specify) no
(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?

18. (a) Signature of funeral director Kriegshausner Und Co
(b) Address 4228 So Kingshighway
19. (a) SEP 21 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature F J Swickard (M. D. or other) MD
Address 1975 Park Ave Date signed 9-20-44

(Licensed Embalmer's Statement on Reverse Side)

on file by
1935 Park

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 Richard W. Storvick

Licensed Embalmer No. 4007

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.