

FILED MAR 12 1945  
128

State File No. ....

Registration District No. ....

Primary Registration District No. 2000

Registrar's No. 146

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 months 17 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 94  
(c) City or town Coodson  
(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 Mrs. Addie Bridges

3. (b) If veteran, name war NONE 3. (c) Social Security No. UNK.

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife John Bridges 6. (c) Age of husband or wife if alive second years  
7. Birth date of deceased March 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months UNK. Days UNK. If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Postmistress

11. Industry or business U.S. Post Office

12. Name Wm. Wiles

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

14. Maiden name Mary Warren

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

16. (a) Informant Mrs. W. J. Smith

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 2-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo, Mo.

18. (a) Signature of funeral director W. B. Jones

(b) Address Buffalo, Mo.

19. (a) 2-24-45 (b) W. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21,  
year 1945 hour 9:45 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from Sept. 5,  
1944, to Feb. 21, 1945  
that I last saw her alive on Feb. 21, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis Duration \_\_\_\_\_  
Hemiplegia  
Diabetes

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Bilateral Hemiplegia  
(Include pregnancy within months of death) Hypertension.

Major findings: \_\_\_\_\_  
Of operation \_\_\_\_\_  
Of autopsy W  
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 W. W. Handley (M. D. or other) 9410  
Address Medford, Springfield, Mo. Date signed 2-23-45

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

39  
19  
6

984

W

AUG 30 1945

**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 E. C. Roof

Licensed Embalmer No. 3044

P. O. Address Springfield Mo

**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.**

X