

FILED APR 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. 8475

Registration District No. 32

Primary Registration District No. 5112 A

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Scopus Rural Acropus twp
(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)

3. (a) PRINT FULL NAME Columbus Palmer Bridges

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Bridges 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased July 19 18 93
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 8 17 no 8 hr. 30 min.

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

10. Usual occupation Farming

11. Industry or business

12. Name F.T. Bridges
13. Birthplace Scopus Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margie Presner
15. Birthplace Seagovickville Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Lyman Bridges

(b) Address Scopus

17. (a) Burial (b) Date thereof Mar 21 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cook's Chapel Cemetery

18. (a) Signature of funeral director John C. Hinder

(b) Address Lutinsville

19. (a) Mar 28 1946 (b) William H. Dawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger
(c) City or town Scopus (If outside city or town limits, write "RURAL")
(d) Street No. None (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1946 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from Oct 17, 1946, to March 19, 1946
that I last saw him alive on March 18, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 7 days

Due to
Due to

Other conditions Acute Leukemia 2mo
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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)
Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury
23. Signature W. H. Dawkins (M. D. or other)
Address Scopus Mo Date signed 3-21-46

RECEIVED

RECEIVED

RECEIVED

at Health Officer No. 4

District File Number 446-1903

Date Filed 4-8-46

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. 2828

P. O. Address Jackson 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April 18
Registrar's No. 18

Registration District No. 32

Primary Registration District No. 51124

1. PLACE OF DEATH:

(a) County Bellinger
(b) City or town Runaway
(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)

3. (a) PRINT FULL NAME

Columbus P. Budger

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex M

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)

July 19
(Month) (Day) (Year)

8. AGE:

Years 52

Months _____

Days _____

(If less than one day)

hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 19 1946 year hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 N. J. Hubbard (M. D. or other) _____
Address Johnson 2nd Date signed 4-18-46

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

7407

SUPPLEMENTARY

8475