

No. 2
v. 5-17-39
I X36671

FILED MAY 16 1946

State File No.

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Nevada
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
227 S. Lynn
(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) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Vernon

(c) City or town Nevada
(If outside city or town limits, write "RURAL")

(d) Street No. 227 S. Lynn
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Bridges

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased April 4th 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 27
year 46 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.

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>0</u>	<u>23</u>	hr. _____ min. _____

Immediate cause of death Coronary Occlusion
had been dead 4 or 5
Due to days when found.

Due to _____

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

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

10. Usual occupation Carpenter

Major findings:
Of operations _____

Of autopsy no.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER {

11. Industry or business _____

12. Name William Bridges

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

14. Maiden name Marley

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

16. (a) Informant Carl Bridges

(b) Address Bollinger, Mo.

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 4-28-46
(Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Richies Funeral Home

(b) Address Nevada, Mo.

19. (a) 4-30-46 (b) Yathum Yancy
(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 _____

(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 Marsh Richies (M. D. or other) Coroner

Address Nevada, Mo. Date signed 4-28

1331

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

MAY 20 1946

MAY 21 1946

RECEIVED
District Health Officer No. 7,
District File Number 4-46-457
Date Filed 5-15-46

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 [Signature]

....., Registered Apprentice No.
working under my personal supervision.

Signed Mark E. Eshinger
Licensed Embalmer No. 2656
P. O. Address Nevada, 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.

State File No. June
Registrar's No. 64

Registration District No. 360

Primary Registration District No. 3076

1. PLACE OF DEATH:
(a) County Wenatchee Nevada
(b) City or town _____
(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 John Bridges
3. (b) If veteran _____ (c) Social Security
number _____ No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased April 4 (Month) (Day) (Year)

8. (AGE: Years Months Days If less than one day)
75 yr. _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 4-30-46 (b) Kathryn Jancy
(Date received local registrar) (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 _____ 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 _____

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

Major findings:
Of operations _____
Of autopsy _____

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

SUPPLEMENTARY

MOTHER FATHER

WRITE PLAINLY—USE UNFADING BLACK INK—NEVER

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

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