

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ALEXIAN BROS HOSPO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. L.
(c) City or town CLAYTON RR #1
(If outside city or town limits, write "RURAL")
(d) Street No. LINDBERGH CONWAY NR.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES M. BRIGHT, SR

3. (b) If veteran, name war _____
3. (c) Social Security No. 498-05-3554

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife MARY BRIGHT
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased JAN 15 1895
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation GARDENER

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN BRIGHT
13. Birthplace ENGLAND
14. Maiden name AMELIA MASON
15. Birthplace DENMARK
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Bright
(b) Address Clayton, Mo. RR #1

17. (a) BURIAL (b) Date thereof 12-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation ST. PETERS CEM.

18. (a) Signature of funeral director Louis H. Bopp, INC
(b) Address KIRKWOOD, Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23
year 1946 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from Dec 18 to Dec 23 1946
that I last saw him alive on Dec 23 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Metastatic Lung
Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration 6 7/8
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 J. F. Bredeck (M. D. or other) _____
Address 607 1/2 Green Date signed 12/24

DEC 26 1946

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

40534

1086

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 Peter B. Dubrouillet

Licensed Embalmer No. 3691

P. O. Address Richmond Heights

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.