

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12992

State File No. _____

Registration District No. 99

Primary Registration District No. 4169

Registrar's No. 11

1. PLACE OF DEATH:

(a) County De Kalb

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

(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 47 years
(Month) (Year) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb 32

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

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME MINERVA ANN BRIDGES

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1947 hour 1 minute 25 A.M.

21. I hereby certify that I attended the deceased from Aug 3rd 1943 to March 28 1947
that I last saw her alive on March 28 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married

Name of husband or wife Osia Bridges (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Dec 14 1876
(Month) (Day) (Year)

Immediate cause of death Carcinoma of urinary bladder

Due to _____

Duration 7 MO

8. AGE: Years 71 Months 3 Days 13 If less than one day _____ hr. _____ min.

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

Major findings: 52B
Of operations _____

Of autopsy _____

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

10. Usual occupation housewife

MOTHER FATHER

11. Industry or business _____

12. Name Martin Crow

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

14. Maiden name Sarah Howard

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Osia Bridges

(b) Address Maysville

17. (a) Burial (b) Date thereof 3-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maysville Mo

18. (a) Signature of funeral director John Brown

(b) Address Maysville Mo

19. (a) 4-15-47 (b) Robert Anderson
(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? 2

(Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature R.R. Reynolds (M. D. or other) NO

Address Maysville Mo Date signed 3/31/47

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *John S. Brown*.....

Licensed Embalmer No 3933.....

P. O. Address Wayville 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.