

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20816**
Registrar's No. **5934**

FILED JUL 15 1949

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 11-4160 Hairfall	

3. NAME OF DECEASED (Type or Print) Pink	a. (First)	b. (Middle)	c. (Last) Bridges	4. DATE OF DEATH (Month) (Day) (Year) June 30 1949
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 10, 1884	9. AGE (In years last birthday) 65	10. UNDER 1 YEAR Months 4 Days 20	11. UNDER 1 HRS. Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kosciusko, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Luany Bridges
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Charlie Bridges	ADDRESS 4002 Selmer
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease, Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Benign Arterioneurosclerosis		INTERVAL BETWEEN ONSET AND DEATH Undet.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Hit by X

22. I hereby certify that I attended the deceased from **6-18**, 19 **49**, to **6-30**, 19 **49**, that I last saw the deceased alive on **6-30**, 19 **49**, and that death occurred at **7:20p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Hedrick M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 7-2-49
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24a. BURL, CREMA-TION, REMOVAL (Specify) Burial	24b. DATE July 8, 1949	24c. NAME OF CEMETERY OR CREMATORY Father Dickson	24d. LOCATION (City, town, or county) (State) Kirkwood Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Paster	25. FUNERAL DIRECTOR'S SIGNATURE G. B. Koonce	ADDRESS 1221 N. Grand
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Jeffrey E. Cooper

Licensed Embalmer No. 4200

P. O. Address 1221 S. Grand

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.