No. 300
10.48

FILED APR 7 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8131

BIRTH NO. _____ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 40

411
4

1. PLACE OF DEATH
a. COUNTY: Harrison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bethany
c. LENGTH OF STAY (In this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lacy Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Harrison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cainsville 6410
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Huldah
b. (Middle): Emily
c. (Last): Bridge

4. DATE OF DEATH (Month) (Day) (Year): March 25, 1952.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: August 25 1875
9. AGE (In years last birthday): 76 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri 0
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Hiram Stanley
13b. MOTHER'S MAIDEN NAME: Mary Jane Hogan
14. NAME OF HUSBAND OR WIFE: Charlie Bridge (Deceased.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Frances Doran, Davenport, Iowa.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral thrombosis — 4 mos.
DUE TO (c) Generalized arteriosclerosis — 3 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — 10 years.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 332 X
20. AUTOPSY? YES ☐ NO ☐

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-14, 1950, *to* 3-25, 1952, *that I last saw the deceased alive on* 3-25, 1952, *and that death occurred at* 5:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leonard R. Lee (Degree or title): M. D.
23b. ADDRESS: Bethany, Missouri.
23c. DATE SIGNED: 3/26/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar. 27, 1952
24c. NAME OF CEMETERY OR CREMATORY: Cain Cemetery
24d. LOCATION (City, town, or county) (State): RFD Cainsville, Mo.

DATE REC'D BY LOCAL REG.: 4/1/52
REGISTRAR'S SIGNATURE: Zola Burris 116
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Cainsville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

THE BUREAU OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

DEATH NO. ..... REG. DIST. NO. ..... PRIMARY REG. DIST. NO. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write "RURAL") OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution, give last place of residence)
a. STATE
b. COUNTY
c. CITY (If outside corporate limits, write "RURAL") OR TOWN
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First)
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)

5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years) Last birthday
10. IF UNDER 1 YEAR Months Days Hours Minutes
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
12. KIND OF BUSINESS OR INDUSTRY
13. BIRTHPLACE (State or foreign country)
14. CITIZEN OF WHAT COUNTRY
15. FATHER'S NAME
16. MOTHER'S MAIDEN NAME
17. NAME OF HUSBAND OR WIFE
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
19. SOCIAL SECURITY NO.
20. INFORMANT'S SIGNATURE OR NAME
21. ADDRESS

22. CAUSE OF DEATH
Enter only one cause for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthenia, anoxia, hypostasis.
INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)
DUE TO (b)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

23. WAS OPERATION PERFORMED? (Yes, no, or unknown)
24. IF OPERATION, DATE OF LAST OPERATION
25. WAS AUTOPSY PERFORMED? (Yes, no, or unknown)
26. TIME OF INJURY (Month) (Day) (Year)
27. HOW DID INJURY OCCURRE
28. PLACE OF INJURY (Specify home, farm, factory, office, street, etc.)
29. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
30. ACCIDENT SUICIDE HOMICIDE

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 in my working under my personal supervision.

☐ YES ☐ NO

Eddie J. Stoklase

Student Embalmer No. .....

Student .....

Student Embalmer

Signed

Licensed Embalmer No. 3602

P. O. Address Cainsville, Missouri.

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.

31. BURIAL, CREMATION, REMOVAL (Specify)
32. NAME OF CEMETERY OR CREMATORY
33. DATE
34. DATE RECD BY LOCAL REG.
35. REGISTRAR'S SIGNATURE
36. FUNERAL DIRECTOR'S SIGNATURE
37. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)