

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41895

State File No.

FILED DEC 31 1952

BIRTH NO. _____		REG. DIST. NO. <u>99</u>		PRIMARY REG. DIST. NO. <u>4168</u>		Registrar's No. <u>52</u>	
1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>DeKalb</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Maysville</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>Maysville</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>M Home In Town</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Asa</u>		b. (Middle)		c. (Last) <u>Bridges</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>10</u> <u>53</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug. 15, 1873</u>	
9. AGE (In years less birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>XXXXXX</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Glen Bridges</u> ADDRESS <u>Maysville Mo</u>			
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) <u>Coronary Arteriosclerosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				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)		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 <u>April, 1943</u> to <u>12/10</u> , 19 <u>53</u> that I last saw the deceased alive on <u>12/10</u> , 19 <u>53</u> and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. Steadford Fowler, M.D.</u>		23b. ADDRESS <u>Maysville Mo</u>		23c. DATE SIGNED <u>12/11/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12, 11-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>Maysville Mo</u>	
DATE REC'D BY LOCAL REG. <u>12-23-52</u>		REGISTRAR'S SIGNATURE <u>Adrian Davidson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Brown</u>		ADDRESS <u>Maysville</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Student Embalmer No.....

Licensed Embalmer No..... 3933

P. O. Address..... Maysville 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.