

FILED DEC 21 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42547

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1115

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield	c. LENGTH OF STAY (In this place) 9 Days	c. CITY OR TOWN Strafford	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL		e. STREET ADDRESS (If rural, give location) Route # 2 0340 /	

3. NAME OF DECEASED (Type or Print)	a. (First) Steve	b. (Middle) Ross	c. (Last) Bridges	4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1953
-------------------------------------	-------------------------	-------------------------	--------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 7/18/1886	9. AGE (In years last birthday) 67	# UNDER 1 YEAR Months 4 Days 15	# UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	--	-----------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and State or Foreign Country) Fair Grove, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	--

13a. FATHER'S NAME William Bridges	13b. MOTHER'S MAIDEN NAME Sarah Huff	14. NAME OF HUSBAND OR WIFE Bertha Dooley
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Marie Snyder, Rt. # 2, Strafford, Mo	ADDRESS
---	---	---	-----------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Mitrol Stenosis Cardiac Decompensation DUE TO (c) Rheumatic fever in early life.		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

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) 410X (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I attended the deceased from 12/6/53, 1953, to 12/15/53, 1953, that I last saw the deceased alive on 12/14/53, 1953, and that death occurred at 1:50 AM from the causes and on the date stated above.

23a. SIGNATURE Deland E. Wetzel (Doctor or title)	23b. ADDRESS 700 E. Sunshine, Springfield	23c. DATE SIGNED 12/15/53
--	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-17-53	24c. NAME OF CEMETERY OR CREMATORY BASS CHAPEL CEMETERY	24d. LOCATION (City, town, or county) (State) GREENE COUNTY Mo.
---	---------------------------	--	--

DATE REC'D BY LOCAL REG. 12-17-53	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Keinguel + Co.	ADDRESS Springfield, Mo.
--	---	---	---------------------------------

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Ogle Stone Jr.

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.