

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42217**Registrar's No. **10837**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 25 yrs.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 904 N. Euclid	
3. NAME OF DECEASED (Type or Print) a. (First) Flossie b. (Middle) Elise c. (Last) Bridges		4. DATE OF DEATH (Month) 11 (Day) 26 (Year) 54	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8/8/1911
9. AGE (In years last birthday) 43	10. MONTHS 3	11. BIRTHPLACE (City and State or Foreign Country) Farmington, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Pvt. Family	13a. FATHER'S NAME Moses Bridges	
13b. MOTHER'S MAIDEN NAME Ellen Taylor		14. NAME OF HUSBAND OR WIFE --	
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. 492-22-9328	17. INFORMANT'S SIGNATURE OR NAME Zella Breeden, 3905 West Belle Pl.	
18. CAUSE OF DEATH Enter only one cause per line for (a); (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix with Metastasis INTERVAL BETWEEN ONSET AND DEATH Undt. *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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) (COUNTY) (STATE)	
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? 171X	
22. I hereby certify that I attended the deceased from 5-26 , 19 54 , to 11-26 , 19 54 , that I last saw the deceased alive on 11-26 , 19 54 , and that death occurred at 12:30A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) William L. Smiley M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 11-26-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/29/54	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
DATE REC'D BY LOCAL REG. NOV 29 1954	REGISTRAR'S SIGNATURE Charles J. Gates	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 4107 Finney Ave.	

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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 4107 Finney A

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.