

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39501

State File No.

FILED NOV 28 1955

BIRTH NO. _____ REG. DIST. NO. 370 PRIMARY REG. DIST. NO. 6234 Registrar's No. 45

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wayne</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Wayne</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Coldwater</u> | | c. CITY OR TOWN <u>Coldwater</u> | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | • STREET ADDRESS (If rural, give location) <u>1110</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION | | | |

| | | | | |
|-------------------------------------|-------------------------|---------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Susie</u> | b. (Middle) <u>Pronia</u> | c. (Last) <u>Bridges</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 20, 1955</u> |
|-------------------------------------|-------------------------|---------------------------|--------------------------|--|

| | | | | | | |
|----------------------|-------------------------------|---|--------------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>May 20, 1878</u> | 9. AGE (In years last birthday) <u>77</u> | 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) <u>Housework</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Coldwater, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|---|--|--|

| | | |
|---|--|--|
| 13a. FATHER'S NAME <u>Hampton White</u> | 13b. MOTHER'S MAIDEN NAME <u>Susan Wakefield</u> | 14. NAME OF HUSBAND OR WIFE <u>William Bridges</u> |
|---|--|--|

| | | | |
|--|-------------------------|--|-------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME <u>Ona Bridges</u> | ADDRESS <u>Coldwater, 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 | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Stenosis</u> | | |
| | ANTECEDENT CAUSES Morbid 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. | | <u>4211</u> | |

| | | |
|------------------------|----------------------------------|--|
| 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? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 1944 to Nov, 1955, that I last saw the deceased alive on Nov 20, 1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

| | | |
|---|------------------------------------|----------------------------------|
| 23a. SIGNATURE (Degree or title) <u>O.A. Myers M.D.</u> | 23b. ADDRESS <u>Coldwater, Mo.</u> | 23c. DATE SIGNED <u>11-23-55</u> |
|---|------------------------------------|----------------------------------|

| | | | |
|---|--------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Nov. 23, 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>White</u> | 24d. LOCATION (City, town, or county) (State) <u>Coldwater, Mo.</u> |
|---|--------------------------------|---|---|

| | | | |
|--|--|---|--------------------------------|
| DATE REC'D BY LOCAL REG. <u>11-25-55</u> | REGISTRAR'S SIGNATURE <u>Hetta M. Hale</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Gish Funeral Home</u> | ADDRESS <u>Greenville, Mo.</u> |
|--|--|---|--------------------------------|

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

NOV 25 1955
WAYNE CO. HEALTH CENTER
FILE NO.

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 *ME* Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Marion E. Bowler*

Licensed Embalmer No. *442*

P. O. Address *Piedmont*

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.