

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14598

FILED APR 26 1956

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State File No. 3580
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____					
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 town or township) ST. LOUIS, MISSOURI			c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		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 ST. LOUIS CITY HOSPITAL #1.				e. STREET ADDRESS (If rural, give location) 1604 Tower Grove				21870			
3. NAME OF DECEASED (Type or Print) MAGGIE Bridges			a. (First)		b. (Middle)		c. (Last)				
4. DATE OF DEATH (Month) (Day) (Year) APRIL 9, 1956		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH April 9, 1878			
9. AGE (In years last birthday) 78		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Salem, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME John Groves			13b. MOTHER'S MAIDEN NAME America			14. NAME OF HUSBAND OR WIFE Unknown			Charles Bridges		
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. None			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Leola Walsh, 7470 Ethel Ave.					
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>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease 5 years</u> DUE TO (c) <u>Hypertensive Cardio-vascular Disease 5 years</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH. 3 weeks		
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) 420.0						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <u>3-27</u> , 19 <u>56</u> to <u>4-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9</u> , 1956, and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>John F. Clisam</u>					23b. ADDRESS 1515 LAFAYETTE AVE.			23c. DATE SIGNED 4-9-56.			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-9-56		24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Sligo, Mo.					
DATE REC'D BY LOCAL REG. APR 10 1956		REGISTRAR'S SIGNATURE <u>Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.						

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

APPROVED

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..... *Robert M. Murray*
Licensed Embalmer No. *37*

P. O. Address *St. Louis*

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.