

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44254

STATE FILE NUMBER

FILED JAN 8 1958

Registration District No. _____

149

Primary Registration District No. _____

1002

Registrar's No. _____

6000

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp.		Length of stay in lb 38 years	
3. NAME OF DECEASED (Type or print) Mr. Byron B. Bridges		4. DATE OF DEATH Month Day Year Dec. 17, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor - Associated Press		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Slater, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William H. Bridges		13b. MOTHER'S MAIDEN NAME Nora Cobb Cobb	
14. NAME OF HUSBAND OR WIFE Bina C. 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. 495-01-2980		17. INFORMANT Address Bina C. Bridges 5422 Charlotte	
18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 331 X
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1956, May to 12/17/57 and last saw him alive on 12/16/57 Death occurred at _____ m on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Daguer or title) Robert W. Hamill		22b. ADDRESS 4620 J C Nichols Hwy	
22c. DATE SIGNED 12/18/57		23a. NAME OF CEMETERY OR CREMATORY Ridge Park Cemetery	
23b. DATE Dec. 19, 1957		23c. LOCATION (City, town, or county) (State) Marshall, Missouri	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 12-18-57	
26. REGISTRAR'S SIGNATURE Irene Marshall			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.