

FILED JAN 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45165
STATE FILE NUMBER

Registration District No. 242 Primary Registration District No. 4361 Registrar's No. 2

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission only) a. STATE <u>MO</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Casslow</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Casslow</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Length of stay in 1b _____		d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Bridwell</u> Middle Last		4. DATE OF DEATH <u>12-20-1957</u> Month Day Year	
5. SEX <u>F.M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>64</u>	9c. 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)		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Marion, Mo.</u>
13. FATHER'S NAME <u>Samuel Young</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. MOTHER'S MAIDEN NAME <u>Lizzie</u>		15. WAS DECEASED EVER IN U. S. ARMED SERVICES (Yes, no, or unknown) (If yes, give year or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Roy Bridwell</u> Address <u>Casslow, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Uterus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized metastases, brain</u>			UNKNOWN
DUE TO (c) <u>lung, liver, pleura, skin, bone</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 WORK <input type="checkbox"/> NOT WHILE AT 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 <u>9/57</u> to <u>12/17/57</u> and last saw ^{her} _{him} alive on <u>12/19/57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Date or title) <u>Ralph Franklin, M.D.</u>		22b. ADDRESS <u>Monchouse, Mo.</u>	
		22c. DATE SIGNED <u>12/28/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/22/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounts Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lelbourn, Mo.</u> (State) _____
24. FUNERAL DIRECTOR <u>Liberton Funeral Home</u> ADDRESS <u>Liberton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-28-57</u>	
		26. REGISTRAR'S SIGNATURE <u>Halcynd L. M. Bain</u>	

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(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED DEC 31 1957

NEW MADRID CO. HEALTH CENTER

P. J. L.

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 [Signature].....

Licensed Embalmer No. 767

P. O. Address [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. - (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.