

UR I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007982

FILED VS MAR 7 1960

Registration District No.

Primary Registration District No.

Registrar's

2 2112

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		a. STATE Mo b. COUNTY	
Length of stay in 1b		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3401 Eads		d. STREET ADDRESS (If outside, give location) 3401 Eads	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Rexie L. Bridges			4. DATE OF DEATH Month Day Year 2/21/60		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY street car		11. BIRTHPLACE (City and state or country) Cuba Ky	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME John H. Bridges		13b. MOTHER'S MAIDEN NAME Lizzie Batts	
14. NAME OF HUSBAND OR WIFE Margie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) yes H. H. I.		16. SOCIAL SECURITY NO. 494-01-0415	
17. INFORMANT Mrs. M. Bridges		Address 3401 Eads			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION		5 MIN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE	5 YEARS
	DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED	5 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERTENSION 420.0		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 DEC. 5, 1952 to FEB. 24, 1960 and last saw ^{her} _{him} alive on FEB. 21, 1960
Death occurred at 11:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert G. Hall, M.D.	22b. ADDRESS 3902 LAFAYETTE ST. LOUIS, MO.	22c. DATE SIGNED FEB. 23, 1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/24/60	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus	23d. LOCATION (City, town, or county) (State) St. Louis County Mo
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24. FUNERAL DIRECTOR Jas. A. Howard 1619 So. Grand	25. DATE RECD. BY LOCAL REG. FEB 23 1960	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence M. Billo

Licensed Embalmer No. *4375*

P. O. Address *ST. LOUIS 23*

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