OCT 30 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
30507

1. PLACE OF DEATH
County: Marion — Registration District No.: 541 — File No.:
Township: Mason — Primary Registration District No.: 3029 — Registered No.: 246
City: Hannibal (No.: , Levering Hospital St.: 6th Ward:)

2. FULL NAME Floss E. Bridges
(a) Residence. No. 520 Willow St., 6th Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF Edwin O. Bridges

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 20-1887

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
43	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) Kinderhook
(STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER Geo. O. Thompson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY) Montgomery Co Ohio
12. MAIDEN NAME OF MOTHER Emma Clutch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kinderhook
(STATE OR COUNTRY) Illinois

14. INFORMANT Mrs. E. O. Bridges
(Address) 520 Willow St Hannibal, Mo

15. FILED 9/18, 1930 E. E. Cousins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 17, 1930, that I last saw her alive on Sept 17, 1930, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Probable embolism in brain
Instantaneous Death.
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fractured arm & leg Sept 2, 1930. Automobile Accident.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. E. Hilton, M.D.
, 19 (Address) 500 Broadway Hannibal, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 19 1930

20. UNDERTAKER: Wm M. Smith — ADDRESS: 902 Broadway Hannibal, Mo.

N. B.—Every item of information known should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to be very careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Marion — Registration District No. 547 — File No.
Township — Primary Registration District No. 3029 — Registered No. 246
City Hannibal (No. ..., ... St. ..... Ward)

2. FULL NAME Floss L. Bridges

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Accident occurred at Salem, Mo. Was in car and skidded on loose gravel.

14. INFORMANT
(Address)

15. FILED 9/18 1930 C E Clausius
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Probable — Embolism in Brain
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured arm & leg
Auto accident (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

..... DATE OF .....

..... M. D

...EATH, or in deaths from VIOLENT CAUSES, state ...r, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

EMENTARY

N. B.—Every ... should state CAUSE OF ... plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFAILING INK ... FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REGISTRAR

S-30507