

JUL 2 2 1935

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 31002  
Research Hospital

File No. 19727  
Registered No. 2366  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Louvenia Bridges

(a) Residence, No. 1225 Bales St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 26, 1903

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
31      7      13

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrisonville Mo

13. NAME Bert Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

15. MAIDEN NAME Fannie Bybee

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Frank Bridges 1225 Bales

18. BURIAL, CREMATION, OR REMOVAL PLACE Freeman Mo DATE June 10, 35

19. UNDERTAKER (ADDRESS) Atkinson Bros Eastern

20. FILED 7/10 1935 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 35 19

22. I HEREBY CERTIFY that Louvenia Bridges died on \_\_\_\_\_, 19\_\_\_\_.

I last saw her alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 8:30 P.M.

The principal cause of death and related causes of importance were as follows:

Myocardial Infarction  
Siphonema

Date of onset

Other contributory causes of importance

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_



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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township                       
City Kansas City (No.                     )

Registration District No. 399  
Primary Registration District No. 1002

File No.                       
Registered No. 2366  
St.                      Ward                     

**2. FULL NAME** Louvenia Bridges

(a) Residence, No.                      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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1935

22. I HEREBY CERTIFY, That I attended deceased from                     , 19                    , to                     , 19                    .

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

I last saw                      alive on                     , 19                    . Death is said

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

to have occurred on the date stated above, at                      m.

7. AGE YEARS MONTHS DAYS If LESS than day, hr. or min. 31 7 13

The principal cause of death and related causes of importance were as follows:

infected abortion Date of onset                       
Sepsis

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.                       
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.                       
10. Date deceased last worked at this occupation (month and year)                      11. Total time (years) spent in this occupation                     

Other contributory causes of importance: Self Induced

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)                     

13. NAME                     

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)                     

15. MAIDEN NAME                     

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)                     

17. INFORMANT (ADDRESS)                     

18. BURIAL, CREMATION, OR REMOVAL

PLACE                      DATE                     , 19                    

19. UNDERTAKER (ADDRESS)                     

20. FILED 2/10, 1935 M. J. Brown Registrar

Name of operation                      Date of                     

What test confirmed diagnosis?                      Was there an autopsy?                     

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?                      Date of injury                     , 19                    

Where did injury occur?                      (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.                     

Manner of injury                     

Nature of injury                     

24. Was disease or injury in any way related to occupation of deceased?                     

If so, specify (Signed) A. J. Litch, M. D.

(Address)

5-19727