

FILED SEP 10 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 316

Primary Registration District No. 306A

Registrar's No. 273

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town Farmington, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 8 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
 (c) City or town Farmington
 (If outside city or town limits, write "RURAL")
 (d) Street No. 408 East Spring
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Jerry Bridges

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Jerry

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May (Month)

5 (Day) 1864 (Year)

8. AGE:

Years	Months	Days
82	3	26

If less than one day
 hr. _____ min. _____

9. Birthplace St. Francois Co. (City, town, or county)

Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown

13. Birthplace Unknown (City, town, or county)

(State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county)

(State or foreign country)

16. (a) Informant Phillip Bridges

(b) Address Farmington Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (Month) (Day) (Year)

(c) Place: burial or cremation Colored Masonic

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington Mo.

19. (a) 9-2-46 (Date received local registrar) (b) Cather Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31
 year 1946 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from August 9, 1946 to August 31, 1946
 that I last saw him alive on August 30, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Passive congestion of lungs
Arterio sclerosis
Senility

Duration
2 days
Yes
Yes

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Walter R. Russell (M: D. or other) Do
 Address Farmington Mo. Date signed 9/2/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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7-39
X35697

RECEIVED

Health Officer No. 4

File Number 946-2569

Date Filed 9-9-46

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Paul Dugal

Licensed Embalmer No. 4120

P. O. Address *Leavenworth 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 this body is not embalmed, fact should be so stated above.

Registration District No. 316 Primary Registration District No. 3060

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Jerry Bridges
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Lucy Bridges 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 5
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-14-46 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1946 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

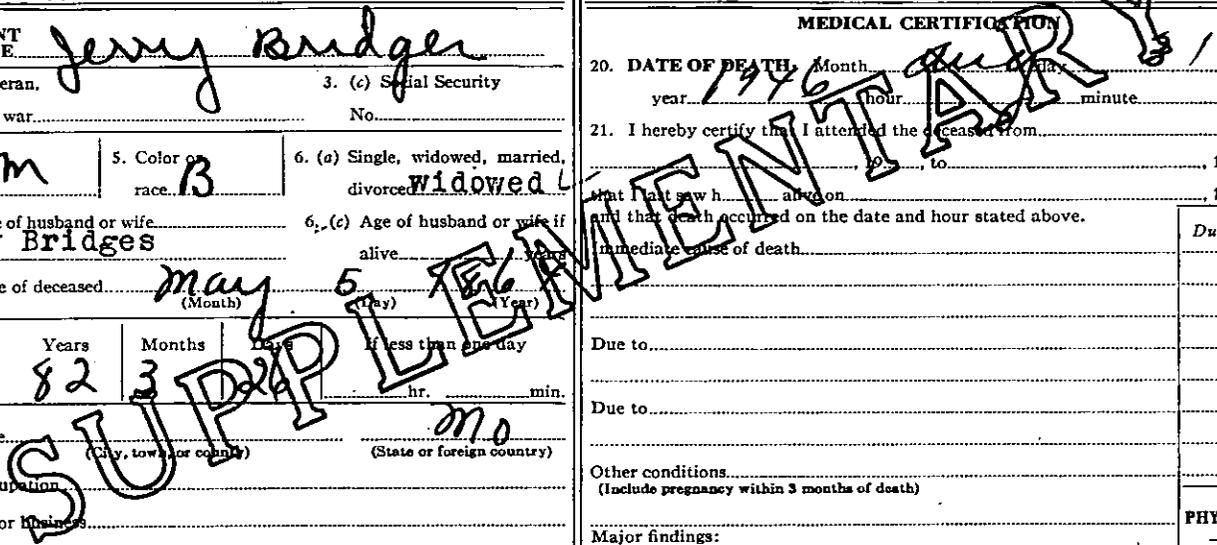
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



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