

FILED NOV 1 1946

STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 334

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Residence, 1717 Chestnut /  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1717 Chestnut  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17  
year 1946 hour 4 minute 20 P. M.  
21. I hereby certify that I attended the deceased from Jan - 1 1946  
Oct 17 1946  
that I last saw him alive on Oct 17 1946  
and that death occurred on the date and hour stated above.

Duration  
30 m

Immediate cause of death  
Beats coronary occlusion  
Due to coronary artery occlusion 27.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 94A

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 Dr. E. M. Lucke (M. D. or other)  
Address Hannibal Mo Date signed 10/17/46

3. (a) PRINT FULL NAME Joseph William Bridges

3. (b) If veteran, name war # 1 3. (c) Social Security No. 490-07-9673

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Marie Bridges 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 28, 1904  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 2 19 hr. min. 0

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

10. Usual occupation Brakeman

11. Industry or business C.E. & O.

12. Name William Albert Bridges

13. Birthplace Tiskilwa, Bureau Co. Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Lee Davis

15. Birthplace Cooper County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. W. Bridges

(b) Address 1717 Chestnut Hannibal Missouri

17. (a) Burial (b) Date thereof 10/19/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director H. Crawford Smith

(b) Address 902 Broadway Hannibal, Missouri

19. (a) 10-22-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

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

norton

11-22-46

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**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 W. Crawford Smith

Licensed Embalmer No. 3814

P. O. Address Hannibal Missouri

**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.**