

U.S. No. 2
FORM-5-43
Rev. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1905**
Registrar's No. **84**

Registration District No. **239** Primary Registration District No. **5825**

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Malden R. 1 Co. Mo.
(c) Name of hospital or institution:
Name 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Gloria Jean Bridges
3. (b) If veteran, name war — 3. (c) Social Security No. 5

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced infant
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Jan - 17 - 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 hr. min.

9. Birthplace Malden Mo R. 1
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business —
12. Name Chester Bridges
13. Birthplace Buck Horn Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lela Mae Mabry
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Chester Bridges
(b) Address Malden, Mo. R. 1

17. (a) Burial (Burial, cremation, or removal) Malden (New Cemetery)
(b) Date thereof 1-21-47
(Month) (Day) (Year)
(c) Place: burial or cremation Malden (New Cemetery)

18. (a) Signature of funeral director Friends
(b) Address Malden, Mo. R. 1

19. (a) 2-2/47 (b) Dr. H. W. Husted
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Malden R. 1
(If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1947 hour — minute 1:15 A.M.

21. I hereby certify that I attended the deceased from Jan 17, 1947, 1947, to Jan 21, 1947, 1947
that I last saw her alive on Jan 21, 1947, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Malformation in region of stomach and lungs, lungs due to acute lunge - swollen with oral feeding regurgitated
Duration —

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 H. W. Husted (M. D. or other)
Address Malden Date signed Jan 21/47

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

2
6
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RECEIVED

District Health Office No. 2,

District File Number 247-176

Date Filed 2-7-49

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.....

..... not embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.