

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046749

STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3356

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>4202 West Cook</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <u>Robert Koch Hosp.</u>			Length of stay in lb <u>1368 days</u>		d. STREET ADDRESS <u>St. Louis.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>James Louis Bridgers</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>58</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/28/1894</u>		9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>		11. BIRTHPLACE (City and state or country) <u>Holcomb, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Scott Bridgers</u>				14. MOTHER'S MAIDEN NAME <u>Laura Pickle</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes, Army</u>			16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Robert Koch Hospitals record.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>002X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>9/22/55</u> to <u>12/18/1958</u> and last saw <u>him</u> alive on <u>12/18/1958</u> Death occurred at <u>12/19/58 5:45am</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Ellis J. Lipins</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Robert Koch Hospital, Koch</u>			22c. DATE SIGNED <u>12/20/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>22 Dec. 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) <u>Grenada</u>		23e. STATE <u>Miss.</u>		
24. FUNERAL DIRECTOR <u>Reliable Funeral Sys. 1389 N. Union</u>				25. DATE RECD. BY LOCAL REG. <u>12-22-58</u>		26. REGISTRAR'S SIGNATURE <u>Verliert R. Dombke</u>			

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *John A. Cunningham* .....  
Licensed Embalmer No. 747

P. O. Address 2405 N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.