

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010182
STATE FILE NUMBER

FILED APR 2 1959 Registration District No. 209 Primary Registration District No. Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Philadelphia		c. CITY OR TOWN Philadelphia ⁰⁶⁴⁶	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) Rural Route 1	

3. NAME OF DECEASED (Type or print) First Lydia Middle Bright Last Bright			4. DATE OF DEATH Month March Day 27 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1869	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months 0 Days 26	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Shelby Co., Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Benjamin Jones	13b. MOTHER'S MAIDEN NAME Sarah Keck	14. NAME OF HUSBAND OR WIFE Samuel Bright
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Edith Doscher Philadelphia, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis / Heart Dis.		INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 4200		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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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 _____
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Henry H Sweet MD Coroner	22b. ADDRESS 1 Hannibal mo	22c. DATE SIGNED 3/30/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE mar. 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery	23d. LOCATION (City, town, or county) (State) Philadelphia, Missouri
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24. FUNERAL DIRECTOR Feaster-Garnes Philadelphia, Mo.	25. DATE RECD. BY LOCAL REG. 3-31-59	26. REGISTRAR'S SIGNATURE Dr. E. M. Lucke <i>By Viola Geer, Deputy</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James Turner*

Licensed Embalmer No. *372*

P. O. Address *Monroe Ct*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.