

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025692

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6734

STATE FILE NUMBER

FILED JUL 5 1963

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Deaconness Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri.</u>		Length of stay in lb <u>30 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconness Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>821 Chestnut Street</u>
3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>E.</u> Last <u>Bridgeford</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/1935</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Man Power, Inc.</u>	11. BIRTHPLACE (City and state or country) <u>Ohio</u>
13a. FATHER'S NAME <u>Russell Bridgeford</u>		13b. MOTHER'S MAIDEN NAME <u>Vesper Davis</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		16. SOCIAL SECURITY NO. <u>93</u>	17. INFORMANT Address <u>Nabel Bridgeford 11702 Abington Detroit, Michigan</u>
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO (b) <u>Squamous carcinoma of pharynx</u> DUE TO (c) <u>148x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT, SUICIDE, HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year _____		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>May 1, 1963</u> to <u>June 21, 1963</u> and last saw <sup>her</sup> <sub>him</sub> live on <u>June 19, 1963</u> Death occurred at <u>12:00 AM June 21, 1963</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Robert Thomasson M.D.</u>		22b. ADDRESS <u>100 N. Euclid, St. Louis</u>	22c. DATE SIGNED <u>6-26-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 27, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann &amp; Son, Inc., 2161 E. Fair St. Louis, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 27 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_  
**NOT EMBALMED**  
Math Hermann & Son, Inc.,  
*Math Hermann*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.