

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **18779**

Registrar's No. **229**

BIRTH NO. _____		REG. DIST. NO. <b>47</b>		PRIMARY REG. DIST. NO. <b>2008</b>		State File No. <b>18779</b>		Registrar's No. <b>229</b>			
<b>1. PLACE OF DEATH</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission.)						
a. COUNTY <b>Callaway</b>					a. STATE <b>Mo</b> b. COUNTY <b>Cole</b>						
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Fulton</b> )			c. LENGTH OF STAY (in this place) <b>2</b> <b>4</b> mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Jefferson City</b>						
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital No 1</b>					d. STREET ADDRESS (If rural, give location) <b>1509 West Main</b>						
<b>3. NAME OF DECEASED</b> (Type or Print)			a. (First) <b>Mary</b>		b. (Middle) <b>Ann</b>		c. (Last) <b>Bridges</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>July 2 1949</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widow</b>		<b>8. DATE OF BIRTH</b> <b>Dec. 2, 1871</b>		<b>9. AGE</b> (In years last birthday) <b>77</b>		<b>10. IF UNDER 1 YEAR</b> (Days) <b>7</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cole Co. Mo</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13a. FATHER'S NAME</b> <b>D. K.</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>D. K.</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>D. K. (dead)</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Hospital records, Fulton, Mo</b>					
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.					<b>MEDICAL CERTIFICATION</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Senile with senile dementia</b>					<b>ANTECEDENT CAUSES</b> <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> <b>DUE TO (b)</b> <b>Heat exhaustion</b> <b>DUE TO (c)</b>					<b>One day</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS</b> <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>										<b>794X</b>	
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)			<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>					
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)			<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from <u>7-1-49</u>, 19<u>  </u>, to <u>7-2-49</u>, 19<u>  </u>, that I last saw the deceased alive on <u>7-1-49</u>, 19<u>  </u>, and that death occurred at <u>2:45 A</u> m., from the causes and on the date stated above.</b>											
<b>23a. SIGNATURE</b> <i>M. D. U</i> (Degree or title)					<b>23b. ADDRESS</b> <b>State Hospital, Fulton, Mo</b>					<b>23c. DATE SIGNED</b> <b>7-2-49</b>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>24b. DATE</b> <b>July 5-1949</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Campbell Crem</b>			<b>24d. LOCATION</b> (City, town, or county) (State) <b>Missouri</b>				
<b>DATE REC'D BY LOCAL REG.</b> <b>July 2-1949</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Martha Lawrence</i>		<b>426</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Russell</i> <b>ADDRESS</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

RECEIVED  
JUL 6 1949  
District Health Officer No. 9  
District File Number

### 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 .....  
Student Embalmer

Signed *G. M. Steffen*

Licensed Embalmer No. 2307

P. O. Address *Princeton, N.J.*

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.