

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **35286**

FILED OCT 29 1957

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3018</u>		Registrar's No. <u>83</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>Dent</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Salem</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY OR TOWN <u>Salem</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hart Clinic</u>				e. STREET ADDRESS (If rural, give location) <u>X</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ronnie</u>			b. (Middle) <u>Dale</u>		c. (Last) <u>Briggs</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 13 1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>X</u>		8. DATE OF BIRTH <u>Oct 12 1957</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 4 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hart Clinic</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13a. FATHER'S NAME <u>Maurice Briggs</u>			13b. MOTHER'S MAIDEN NAME <u>Ethel Leonard</u>		14. NAME OF HUSBAND OR WIFE <u>XX</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Maurice Briggs Salem Cedar Grove rt</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral anoxia</u> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7950</u>				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-13-57</u> , 19 <u>57</u> , to <u>10-14-57</u> , that I last saw the deceased alive on <u>10-14-57</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u>				23b. ADDRESS <u>Salem</u>		23c. DATE SIGNED <u>10/26/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-14-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Salem Dent Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>10/26/57</u>		REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D. - L.P.R.M. (C)</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Salem Mo</u>	

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

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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.....
Licensed Embalmer No. 237
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.