

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047003

FILED DEC 23 1958

State File No. 6224 Registrar's No. 233

BIRTH NO. _____		REG. DIST. NO. 360	PRIMARY REG. DIST. NO. _____	Registrar's No. 233	
1. PLACE OF DEATH a. COUNTY <u>VENETA</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Center Twp.</u>)		c. LENGTH OF STAY (in this place) <u>1 1/2 years</u>	c. CITY OR TOWN <u>Cross Timbers</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>113 1/2 of Nevada - Andersonville #3</u>			e. STREET ADDRESS (If rural, give location) <u>San. Delaney</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Father</u>		b. (Middle) _____	c. (Last) <u>Brigg's</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 14-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>X</u>	9. AGE (in years last birthday) <u>X</u>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) _____		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Alfred Briggs</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Davis-Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Nil</u>		16. SOCIAL SECURITY NO. <u>Nil</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anderson Nursing Home, Nevada, Mo</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Nil</u>			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u>			INTERVAL BETWEEN ONSET AND DEATH _____		
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. DUE TO (b) <u>Stroke of Apoplexy</u>			years _____		
DUE TO (c) _____			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>334 X</u>		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>1955</u> , to <u>Dec. 14, 1958</u> , that I last saw the deceased alive on <u>Dec. 14, 1958</u> , and that death occurred at <u>12 P. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>A. R. Easton</u>		(Degree or title) <u>MD</u>	23b. ADDRESS <u>Franklin Mo</u>		23c. DATE SIGNED <u>Dec. 14, 58</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>12-14-1958</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Whitland Mo</u>		
DATE REC'D BY LOCAL REG. <u>12-5-58</u>		REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert Whitman - Whitland, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Chas. Herbert Helthaus*

Licensed Embalmer No. *426*

P. O. Address *Wheat*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.