

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005443
STATE FILE NUMBER
693

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON M			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 501 W. 11th		Length of stay in lb 30 yrs	d. STREET ADDRESS (If outside, give location) 501 W 11th Apt. 104		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First STELLA Middle BRIGGS Last			4. DATE OF DEATH Month Feb. Day 5 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1893	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental assistant		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	11. BIRTHPLACE (City and state or country) Leavenworth, Ks.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Frank McFadden		13b. MOTHER'S MAIDEN NAME Mary Cahill		14. NAME OF HUSBAND OR WIFE Fred Briggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none		16. SOCIAL SECURITY NO. 495-07-4968	17. INFORMANT Shane Woodward Address 501 W. 11th		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic heart disease - auricular fibrillation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition					INTERVAL BETWEEN ONSET AND DEATH 4 years
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 1955 to Feb 5, 1959 and last saw her ^{her} _{him} alive on Jan 30, 1959 Death occurred at 1:30 p on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E. G. Kettner (Degree or title) M.D.			22b. ADDRESS Kansas City, Mo		22c. DATE SIGNED 2/6/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-7-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR Melody-McGilley-Eylar Linwood		ADDRESS 1800	25. DATE RECD. BY LOCAL REG. 2-6-59	26. REGISTRAR'S SIGNATURE Neva Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

E. G. Kettner

Don K. H. ...
Prof. B. G.
No. 1-2892

11-12:30

1:36-4



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 E. Hackler*

Licensed Embalmer No. *4573*

P. O. Address *K. C. Mo.*

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.