

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013189

STATE FILE NUMBER

1593

APR 20 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 1593

300

1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	f. CITY OR TOWN <b>KANSAS City</b> 3110 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RIVERVIEW Nursing</b>		Length of stay in 1b <b>60 yr.</b>	d. STREET ADDRESS (If outside, give location) <b>1244 Washington</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MONTIE</b> Middle <b>—</b> Last <b>Briggs</b>			4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>59</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 31, 1888</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (City and state or country) <b>PETTIS Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Jerome Briggs</b>	
13b. MOTHER'S MAIDEN NAME <b>unknown - Carpenter</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>495-09-4939</b>	
17. INFORMANT <b>ROSE E. Hodges</b>		Address <b>517 1/2 E 6th JEFFERSON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO (b) <b>Carcinoma of the Prostate</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) <b>1974</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <b>—</b> Month, Day, Year a.m. <b>—</b> p.m. <b>—</b>		20d. INJURY OCCURRED WHILE AT <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 <b>—</b> STATE <b>—</b>	
21. I attended the deceased from <b>1-28-59</b> to <b>3-27-59</b> and last saw him alive on <b>3-26-59</b> Death occurred at <b>9:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert F. Goodwin M.D.</b>		22b. ADDRESS <b>5239 Catalina K.C. 3, Kans.</b>	
22c. DATE SIGNED <b>3-28-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>MAR. 30, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL Cem, KANSAS City, KANS.</b>	
23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, KANS.</b>		24. FUNERAL DIRECTOR ADDRESS <b>GATES FUNERAL HOME, K.C., KANS.</b>	
25. DATE RECD. BY LOCAL REG. <b>3-28-59</b>		26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Robert F. Goodwin

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 *Murray Wilson* .....

Licensed Embalmer No. *4989* .....

P. O. Address *Parkville, 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.