

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022723

STATE FILE NUMBER

Registration No. 6023

FILED JUL 7 1959

Registration District No. Primary Registration District No.

Registration No. 6023

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5927 Susan Pl.		d. STREET ADDRESS (If outside, give location) 5927 Susan Pl.	
3. NAME OF DECEASED (Type or print) First Middle Last MABEL L. BRIGGS		4. DATE OF DEATH Month Day Year June 24 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 May 29, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME John Leahy		13b. MOTHER'S MAIDEN NAME Delia Burgin	14. NAME OF HUSBAND OR WIFE Joseph Briggs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. 499-26-0777	17. INFORMANT Address Kathryne E. Buck 5927 Susan Pl.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arterio Sclerotic heart disease</i> DUE TO (c) <i>Broncho pneumonia</i>			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) 420.0			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 a.m. Month, Day, Year p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <i>17 March 19</i> to <i>24 June 19</i> and last saw her alive on <i>23 June 19</i> Death occurred at <i>5:00 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. H. Kriegshauser</i> (Degree or title) M.D.		22b. ADDRESS <i>2705 Chilton</i>	
22c. DATE SIGNED <i>25 June 19</i>			
23b. DATE <i>June 27, 1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	
23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>			
24. FUNERAL DIRECTOR <i>Kriegshauser 4228 S. Kingshighway</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 25 '59</i>	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

mjb

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 *Richard W. Storvick*

Licensed Embalmer No. *4007*

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.