

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-048344**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 552

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED DEC 18 1963</b>		1. PLACE OF DEATH a. COUNTY <u>Andrew Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		Length of stay in 1b <u>6 Yrs.</u>		c. CITY OR TOWN <u>INDEPENDENCE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>REST HAVEN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1500 W. TRUMAN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>M.</u> Last <u>BRIGGS</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>11</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1873</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>BOZEMAN, MONTANA</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>J.A. GILLEN</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY MOORE</u>	
14. NAME OF HUSBAND OR WIFE <u>J.D. BRIGGS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. JAMES R. HOUGHTON LYNNFIELD CENTER MASS</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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	STATE
21. I attended the deceased from <u>1960</u> to <u>date</u> and last saw her alive on <u>12/11/63</u> Death occurred at <u>2:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Harold W. Keames mo</u>			22b. ADDRESS <u>10901 Winnie Road Independence</u>		22c. DATE SIGNED <u>12/13/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>12-13-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>LAMONE, IOWA</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROLAND R. SPEAKS INDEP. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-13-63</u>		26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>	

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. 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.