NOV 28 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31239

1. PLACE OF DEATH

County Ralls — Registration District No. 725 — File No.

Township — Primary Registration District No. 4431 — Registered No.

City Center (No. ..... St. ..... Ward)

2. FULL NAME Lillian F. Briggs

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Richard T. Briggs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 15 1888

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
39	6	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Nebraska
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Fagler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Nebraska

12. MAIDEN NAME OF MOTHER Sawyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Nebraska

14. INFORMANT Riachard T. Briggs
(Address) ~~Center, Mo.~~

15. FILED Oct 7th 1927 J. T. Howard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 4, 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 4, 1927, that I last saw her alive on Oct 4, 1927, and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis

93 B

57 A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arthritis Deformans

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H B Norton, M. D

Nov 9, 1927 (Address) Center

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Center Cemetry

DATE OF BURIAL: 10/6/27 19

20. UNDERTAKER: Giles R. Hulse

ADDRESS: Center