

**MISSOURI STATEBOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6930

1. PLACE OF DEATH

County Madison Registration District No. 44 File No. _____
 Township Mediana Primary Registration District No. 5092 Registered No. 65
 City Madison (No. 2607) Population _____ St. _____ Ward _____

2. FULL NAME

Benjamin C. Briggs
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Evaline

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4, 1873

7. AGE: YEARS 55 MONTHS 5 DAYS _____
 LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work piano tuner
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Eli Briggs

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

12. MAIDEN NAME OF MOTHER W. Reed

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

14. INFORMANT Evaline Briggs
 (Address) Josephine

15. FILED 2-7, 19 39 Dr. A. B. Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3 - 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him/her alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, at _____ P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardium probably arterio-sclerosis
97

CONTRIBUTORY (SECONDARY) 910
 (duration) _____ yrs. _____ mos. _____ da.
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Tom Simonds, M. D.
2/4, 19 29 (Address) Bonney, Jasper Co.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ozark New Park DATE OF BURIAL 2/7 29

20. UNDERTAKER Hurlbut and Co ADDRESS Josephine

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.

WRITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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220

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