

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

Do not use this space. *Hays*

AY 29 1929

13611

PLACE OF DEATH
 County Wagon Registration District No. 875
 Township Washington Primary Registration District No. 6162
 City Nevada (No.) St. Ward

2. FULL NAME Estelle Briggs
 (a) Residence. No. State Hospital, Ward.
 (Usual place of abode) (If nonresident give city and State)
 Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo. Briggs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29/92

7. AGE YEARS 37 MONTHS 8 DAYS 1 If LESS than 1 day, hrs. or min.

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)

9. BIRTHPLACE (CITY OR TOWN) Sarcosie Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Solomon Shuler

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

12. MAIDEN NAME OF MOTHER Rachel Ferrel

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

14. INFORMANT Geo. Briggs
 (Address) Sarcosie Mo

15. DATE 4/20/29 REGISTRAR E. R. King

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1929 to Mar 30, 1929 that I last saw h. alive on Mar 30, 1929, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Maniacal exhaustion

CONTRIBUTORY (SECONDARY) 84 yrs. mos. 10 ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) J. J. O. Bell, M. D.
3/31, 1929 (Address) Nevada Mo.

*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 Sarcosie Mo. DATE OF BURIAL Mar 30 1929

20. UNDERTAKER Allen U. Hays, Nevada Mo.

36
205
1
2
22

61-10000

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Monroe
Township Washington
City (No. St. Ward)

Registration District No. 846-
Primary Registration District No. 6162

File No.
Registered No. 81

2. FULL NAME Myrtle Briggs

(a) Residence. No. St. Ward.
(Usual place of abode)

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 8 1

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....
- (c) Name of employer.....

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

PARENTS

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT..... (Address)

15. 4-20-29 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 30 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (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)....., M. D.

, 19 (Address)

*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 DATE OF BURIAL
19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED. LAW

SUPPLEMENTARY

S-13611

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