

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

Do not use this space.

40096

File No. _____
Registered No. 371
St. _____ Ward _____

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Mason Primary Registration District No. 3079
City Hannibal No. 1003 North St

2. FULL NAME

Phas Briggs
(a) Residence. No. 1003 North St. 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 63 0 10

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Hubert Briggs

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

12. MAIDEN NAME OF MOTHER Mary Briggs

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

14. INFORMANT Mrs Anna Briggs
(Address) 1003 North St

15. FILED 12/16/30 W. Clausen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15-1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 8:30 PM to Dec 15 1930
that I last saw alive on Dec 15 8:30 PM and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis of Liver

12 1/8 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 12 2 1/2 (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) Horn & Meeker M.D.
12/16/30 (Address) Hannibal 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 Baptist Cem DATE OF BURIAL 12/18 1930

20. UNDERTAKER Geo E Roberts ADDRESS Hannibal

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 very important.

JAN 20 1931

