

MO JAN 8 1941 399

Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City - Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution childrens' mercy Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 1/2 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Briggs

(b) If veteran, name war No (c) Social Security No. No

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced ---

6. (b) Name of husband or wife Infant 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased July 5 1937
(Month) (Day) (Year)

8. AGE: 3 Years 6 Months 20 Days If less than one day
3 5 20 hr. 0 min.

9. Birthplace Leesville, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business 0

12. Name Earl Briggs

13. Birthplace Leesville, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lillie Phillips

15. Birthplace Henry Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Sarah Harvey

(b) Address Clinton, Mo.

17. (a) Burial (b) Date thereof 12-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parks Chapel

18. (a) Signature of funeral director Fred Wilkinson

(b) Address Clinton, Mo.

19. (a) 12-25-40 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry

(c) City or town Clinton
(If outside city or town limits, write "RURAL")

(d) Street No. Route 2
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25 h
year 1940 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec. 22nd
_____ 1940, to Dec 25th, 1940;
that I last saw him alive on Dec. 25th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Generalized Peritonitis

Due to

Ruptured Appendix

Due to

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations _____

Of autopsy Same

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature M. B. Soderberg (M. D. or other)

Address 1316 Park Blvd Date signed Dec 25-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.