

FILED JAN 31 1946

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

217

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether  
 In this community 35 yr  
 years, months or days)

3. (a) PRINT  
FULL NAMEMary Elizabeth Briggs3. (b) If veteran,  
name war no3. (c) Social Security  
No. no

4. Sex Female 5. Color or  
race white  
 6. (a) Single, widowed, married,  
divorced Married  
 6. (b) Name of husband or wife  
Thomas J. Briggs  
 6. (c) Age of husband or wife if  
alive 80 years  
 7. Birth date of deceased May 30, 1973  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 7 12 hr. min.

9. Birthplace (City, town, or county) (State or foreign country) no10. Usual occupation Housewife

11. Industry or business

12. Name Joe Barkeman 713. Birthplace no record 714. Maiden name Elizabeth Barkeman15. Birthplace no16. (a) Informant Lillie Ferring(b) Address 1305 Troost17. (a) Removal (b) Date thereof Jan-15-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Versailles mo18. (a) Signature of funeral director M. C. Foster(b) Address 918 Brooklyn19. (a) 1-15-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1305 Troost  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12  
 year 1946 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from  
Jan. 8 1946 to Jan. 12 1946  
 that I last saw her alive on Jan. 12 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Fibrocaceous pulmonary  
 tuberculosis bilateral

Duration

Due to

Due to

Other conditions.  
 (Include pregnancy within 3 months of death) 13 1/2

Major findings:  
 Of operations

Of autopsy See above

## 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 Clifford Seely (M.D. or other)  
 Address Med. Dir. Gen'l Hosp Date signed 1-14-46

*Dr. Mifeson*

*Dr. Mifeson*

**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..... *Dr. Mifeson*

Licensed Embalmer No. *28-70*

P. O. Address..... *100*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 89

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Hannassee City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Martha Briggs

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 4-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La. Crose, Wisc.

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-8-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6  
 year \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1209