

FILED FEB 17 1947

State File No.

510

Registration District No. 149

Primary Registration District No. 1082

Registrar's No.

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 16 days (Specify whether
In this community 16 days years, months or days)

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. 606 E. 5 St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Ronald Alvin Briggs
3. (b) If veteran, name war no 3. (c) Social Security No. no

20. DATE OF DEATH: Month Jan. day 31
year 1947 hour 10 minute 50 A. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 1947 years
7. Birth date of deceased: Jan 15 (Month) 1947 (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 15, 1947, to Jan. 31, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage with tentorial tear
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations.....
Of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years 0 Months 0 Days 16 If less than one day hr. min.

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

10. Usual occupation: none

11. Industry or business

12. Name: James Briggs

13. Birthplace: 1-1-Mo. (City, town, or county) (State or foreign country)

14. Maiden name: Trances Mc Mully

15. Birthplace: California (City, town, or county) (State or foreign country)

16. (a) Informant: James Briggs

(b) Address: 606 E. 5 St

17. (a) Burial (b) Date thereof: 2-5-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Green Lawn

18. (a) Signature of funeral director: Wm C. Foster

(b) Address: 919 Broadway

19. (a) 2-4-47 (b) Geraldine Holmes (Date received local registrar) (Registrar's signature)

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 0

23. Signature: Wm W. Hunt (M. D. or other) 2-1-47
Address: Med. Dir. Gen'l Hosp. Date signed

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

MOTHER FATHER

*Dr. Kull
Dr. Chalkey*

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 *Orland Minor*

Licensed Embalmer No. *3414*

P. O. Address *918 Beverly*

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.