

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 296277
Registrar's No. 3248

Registration District No. 149

Primary Registration District No. 1002

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

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. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 22 DAYS
(Specify whether years, months or days)
 In this community 10 YRS.

3: (a) PRINT FULL NAME PAULINE BRIGGS
 3. (b) If veteran, name war no | 3. (c) Social Security No. no

4. Sex FEMALE | 5. Color or race NEGRO
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife ELLIS BRIGGS
 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased JULY 6, 1900
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>1</u>	<u>2</u>hr.min.

9. Birthplace CLINTON MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WALLY HALL
 13. Birthplace HUMANSVILLE MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name ELLA THOMAS

15. Birthplace HARRISONVILLE MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant ELLIS BRIGGS (HUSBAND)
 (b) Address 4158 WASHINGTON

17. (a) Removal (b) Date thereof 8-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton Mo

18. (a) Signature of funeral director Adriana Bras Suggal
 (b) Address 2000 E. 12th St. K. C. Mo

19. (a) 8-10-48 (b) Seraldine 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. 4158 WASHINGTON
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 8, year 1948 hour 1: minute 24 A. M.
 21. I hereby certify that I attended the deceased from JULY 17, 1948 to AUGUST 8, 1948
 that I last saw HER alive on AUGUST 8, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death GENERALIZED ARTERIOSCLE- ROSIS
Duration

Due to Lymphoepitheloma of nasal pharynx malignant

Due to

Other conditions NO
(Include pregnancy within 3 months of death)

Major findings: 456
 Of operations
 Of autopsy
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) (c) Means of injury 1
 23. Signature [Signature] (M. D. or other)
 Address GENERAL HOSPITAL NO. 2 Date signed 8/9/48

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 C. Kenneth Gerford
Licensed Embalmer No. 437
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.