

No. 300
10-48

FILED JUN 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16831

State File No. _____

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BIRTH NO. _____ REG. DIST. NO. 275 PRIMARY REG. DIST. NO. 3053 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, write RURAL and give township) Rolla <u>4</u>		c. CITY (If outside corporate limits, write RURAL and give township) Rolla	
c. LENGTH OF STAY (In this place) 8 months		d. STREET ADDRESS (If rural, give location) McFarland Nursing Home	
d. FULL NAME OF HOSPITAL OR INSTITUTION: McFarland Nursing Home			

3. NAME OF DECEASED (Type or Print) JAMES SCOTT BRIGGS			4. DATE OF DEATH (Month) (Day) (Year) May 23, 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH May 10, 1859		9. AGE (In years last birthday) 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Scott Briggs		13b. MOTHER'S MAIDEN NAME Briget Fennesey		14. NAME OF HUSBAND OR WIFE Martha Ann dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. George Miller		ADDRESS Union, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral regurgitation		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.					None

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8-19-, 1948, to 5-23, 1949, that I last saw the deceased alive on 5-23, 1949, and that death occurred at 5:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE Adrian McFarland		23b. ADDRESS Rolla Mo		23c. DATE SIGNED 5-24-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-23-49	24c. NAME OF CEMETERY OR CREMATORY Guardian Angel Cem.		24d. LOCATION (City, town, or county) (State) Brinktown, Mo.	

DATE REC'D BY LOCAL REG. 5-25-49	REGISTRAR'S SIGNATURE Nadine L. Stoll		380 FUNDRAISER'S SIGNATURE Paul E. Null		ADDRESS Rolla, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Phelps County Health Officer,

County File Number _____

Date Filed 6-1-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed
Student Embalmer

Signed Paul E. Null

Licensed Embalmer No. 4498

P. O. Address Rolla, Mo.

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.