

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30018**

No. 300  
10-48

FILED SEP 30 1949

BIRTH NO. _____		REG. DIST. NO. <u>140</u>		PRIMARY REG. DIST. NO. <u>3024</u>		Registrar's No. <u>56</u>	
1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fayette</u>			c. LENGTH OF STAY (in this place) <u>25 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Fayette</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>719 N. Church St</u>				d. STREET ADDRESS (If rural, give location) <u>719 N. Church St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sallie</u>			b. (Middle) <u>Howard</u>		c. (Last) <u>Briggs</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 21 1949</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 20, 1859</u>		9. AGE (In years last birthday) <u>90</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> IF UNDER 6 HRS: Hours <u>1</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Thomas Howard</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Shields</u>		14. NAME OF HUSBAND OR WIFE <u>David Jackson Briggs</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Elizabeth Briggs</u> ADDRESS <u>Fayette, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Arteriosclerosis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u> <u>3 3/4</u> <u>1 yr.</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) _____		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 <u>1-1</u> , 19 <u>49</u> , to <u>9-21</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-21</u> , 19 <u>49</u> , and that death occurred at <u>3 1/2</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. Blount M.D.</u>				23b. ADDRESS <u>Fayette Mo</u>		23c. DATE SIGNED <u>9-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 23 '49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fayette City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fayette, Mo</u>		
DATE REC'D BY LOCAL REG. <u>9-24-49</u>		REGISTRAR'S SIGNATURE <u>Mary L. Shell Deputy</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Carr</u>		ADDRESS <u>Fayette, Mo</u>	

(Licensed Embalmer's Statement of Reverse Side)

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

45  
1

RECEIVED SEP 27

District Health Officer No.

District File Number

Date Filed

9-28-49

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

*Ralph A. Carr*

Signed.....

Student Embalmer

Licensed Embalmer No.

3340

P. O. Address

*Fayette 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.