

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38748

State File No.

FILED DEC 15 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10763**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) ST. Louis		c. CITY (If outside corporate limits, write RURAL and give township) ST. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3810, A. Finney Avenue		e. STREET ADDRESS (If rural, give location) XXXXXX 3810 Finney Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle)	
c. (Last) Briggs		4. DATE OF DEATH (Month) (Day) (Year) II - 30th, - 1951	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH I - 16th, - 1901
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	11. BIRTHPLACE (State or foreign country) Holly Grove Monroe Co. Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Orange. Brown	
13b. MOTHER'S MAIDEN NAME Minervia. unknown		14. NAME OF HUSBAND OR WIFE Joseph. Briggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ?	
17. INFORMANT'S SIGNATURE OR NAME JOE BRIGGS		ADDRESS 3810, A. Finney Ave	
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) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH about 1 year 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.	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? ROCK		22. I hereby certify that I attended the deceased from Nov 14 , 19 51 , to Nov 30 , 19 51 , that I last saw the deceased alive on Nov 30 , 19 51 , and that death occurred at 10 a. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) W. A. Smith M.D.		23b. ADDRESS 536 N. Taylor	
23c. DATE SIGNED 11-30-1951		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12/4/51		24c. NAME OF CEMETERY OR CREMATORY Holly Grove, Monroe Co. Arkansas	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE John H. Houston	
25. ADDRESS 2829, Washington, Blvd		DATE RECORDED BY LOCAL HEALTH DEPT. 12-4-51	

WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

working under my personal supervision.

Signed.....
Student Embalmer

Signed *J. [Signature]*
Student Embalmer No.
Licensed Embalmer No. *4441*
P. O. Address. *2829 [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.