

Health, Welfare  
Public  
Service

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-56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 14 1957.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41372  
STATE FILE NUMBER  
5440

Registration District No. 149 Primary Registration District No. 1009 Registrar's No. 5440

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREEN</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>CLINTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V. A. Hospital</b>			Length of stay in lb <b>4 days</b>		d. STREET ADDRESS <b>1335 Highway Junction</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ORVAL</b>				First <b>B.</b> Middle <b>BRISCOE</b> Last		4. DATE OF DEATH Month <b>12th</b> Day <b>16th</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-18-96</b>		9. AGE (In years last birthday) <b>60 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cafe and beer owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restauranteer</b>		11. BIRTHPLACE (City and state or country) <b>Moberly, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Ralph Briscoe</b>				14. MOTHER'S MAIDEN NAME <b>Addie Clark</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 3-29-17 to 5-8-19</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>V.A. Hospital Records, K.C., Mo.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atrophic cirrhosis of liver</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs plus</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <b>Broncho pneumonia</b>		5 8'		1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. <input checked="" type="checkbox"/> attended the deceased from <b>December 12, 1956</b> to <b>December 16, 1956</b> and <del>was present at</del> Death occurred at <b>7:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Howard P. Fink</b> (Degree or title)				22b. ADDRESS <b>V.A. Hospital, K.C., Mo.</b>			22c. DATE SIGNED <b>12-16-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-17-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>-</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD Missouri</b>			
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>			ADDRESS <b>K.C., MO.</b>		25. DATE RECD. BY LOCAL REG. <b>12-17-56</b>		26. REGISTRAR'S SIGNATURE <b>Meva Minshel</b>		

(Licensed Embalmer's Statement on Reverse Side)

100716

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..

Student.....  
Signature of Student Embalmer

Signed *Paul R. Williamson*

Licensed Embalmer No. *50*

P. O. Address *Overland Park*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.