

Health, Welfare  
Public  
Service

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Use only standard nomenclature in item 18. No symptoms with definite diseases. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

D. J. Dixon 5432  
STATE FILE NUMBER

FILED MAR 12 1957

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 217

1. PLACE OF DEATH a. COUNTY <b>Linn</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Linn</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield Marceline</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Brookfield</b>		0581 0 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Francis Hospital 2 Weeks</b>				Length of stay in 1b		d. STREET ADDRESS <b>512 Harrison</b>	
3. NAME OF DECEASED (Type or print) First <b>ELIAS</b> Middle <b>L</b> Last <b>BRIGG</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</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>Aug - 4 - 1880</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Debraser</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mason Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph B. Briggs</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Spicer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-14-8690</b>		17. INFORMANT Name <b>Earl L. Briggs</b> Address <b>Brookfield Mo</b>			
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>Adenocarcinoma of prostate with metastases to spine + pelvis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
						DUE TO (c)	
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 type="checkbox"/> NO <input checked="" 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.) <b>177X</b>	
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 <b>Brookfield Mo</b>	
20g. COUNTY		STATE		21. I attended the deceased from <b>Feb, 1956</b> , to <b>March 9 57</b> and last saw <b>him</b> alive on <b>3-9-57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John R. Owen M.D.</b>				22b. ADDRESS <b>Brookfield Mo</b>		22c. DATE SIGNED <b>3-10-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Mar-11-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Brookfield Mo</b>	
24. FUNERAL DIRECTOR <b>J. R. Blacklock Brookfield</b>				25. DATE RECD. BY LOCAL REG. <b>3-11-57</b>		26. REGISTRAR'S SIGNATURE <b>Brookie Owens</b>	

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 18 1957

**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 *J. B. Blacklock* .....

Licensed Embalmer No. *23*

P. O. Address *Brookfield*

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.