

Dept. Health,  
& Welfare  
S. Public  
Health Service

FILED JUN 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 017731  
STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 5605 Registrar's No. 14

V. S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Knobnoster</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo Knobnoster</u>		Length of stay in 1b <u>19 yr.</u>	d. STREET ADDRESS (If outside, give location) <u>Mo Knobnoster</u>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Simon</u> Last <u>Bird</u> <u>Briscoe</u>			4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>57</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-1888</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Holden, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Briscoe</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Emma Jo Briscoe</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mrs. Emma Jo Briscoe, Knobnoster, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>-</u> DUE TO (c) <u>-</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old cerebral hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>-</u>
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20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. CITY, TOWN, OR LOCATION <u>Knobnoster</u>	COUNTY <u>Johnson</u>	STATE <u>Mo</u>
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21. I attended the deceased from Death occurred at <u>5:15 pm</u> on <u>June 4-57</u> to <u>June 4-57</u> and last saw him alive on <u>June 4-57</u> m of the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>H. W. Howe M.D.</u> (Degree or title)	22b. ADDRESS <u>Knobnoster, Mo</u>	22c. DATE SIGNED <u>June 5-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-6-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knobnoster Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Knobnoster, Mo</u>
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24. FUNERAL DIRECTOR <u>Bob Brannan</u> <u>E. Keeley</u>	ADDRESS <u>Warrensburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6/5/57</u>	26. REGISTRAR'S SIGNATURE <u>Emma Jo Briscoe</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Securing the medical certification in the specific manner required by 193.140 MBRS 1949.

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JUN 19 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 Earl M. Keeny

Licensed Embalmer No. 3517

P. O. Address Wurensburg

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.