

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014741  
STATE FILE NUMBER

FILED APR 20 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **3263**

300  
1-57  
0  
792  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4235 Flora Pl.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>4235 Flora Pl.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>PHILLIP</b> Middle <b>E.</b> Last <b>BRISCOE</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>1</b> Year <b>1959</b>
5. SEX <b>Male</b> <input type="checkbox"/>	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>May 5, 1876</b>
9. AGE (In years last birthday) <b>82</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President- Independent Paper Cutter Co.</b>	11. BIRTHPLACE (City and state or country) <b>Versailles, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Briscoe</b>	13b. MOTHER'S MAIDEN NAME <b>Jennie Hickerson</b>
14. NAME OF HUSBAND OR WIFE <b>Josephine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-36-6339</b>
17. INFORMANT <b>Josephine Briscoe</b>		Address <b>4235 Flora Place</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>cerebral arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>334X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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. I attended the deceased from Death occurred at <b>Sept 19, 1952</b> <b>12:30 A.M.</b> and last saw her <b>present</b> and last saw her live on <b>Mar 28, 1959</b> m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert M. Smith M.D.</b>		22b. ADDRESS <b>114 N. Taylor</b>	22c. DATE SIGNED <b>Apr 1, 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Apr. 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>APR 1 '59</b>	26. REGISTRAR'S SIGNATURE <b>Robert M. Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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 *William R. White* .....

Licensed Embalmer No. *4291* .....

P. O. Address *428th Street* .....

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.