

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=62-000311**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 130

AMENDED

**FILED FEB 13 1962**

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>   |   | Length of stay in 1b<br><b>11 years</b>   | c. CITY OR TOWN <b>St. Joseph</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Sunnyslope Nursing Home</b><br><b>3225 So. 11th St.</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>Pickett Road, R. R. #4</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>         |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OTIS</b> Middle <b>BRIGGS</b> Last <b>BRIGGS</b>   |   |   | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>2</b> Year <b>1962</b>  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/27/1875</b>   |
| 9. AGE (last birthday)<br><b>86</b>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Stevedor</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad Co.</b>  | 11. BIRTHPLACE (City and state or country)<br><b>BROWN COUNTY, MO.</b>   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   | 13a. FATHER'S NAME<br><b>Thomas B. Briggs</b>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Cora</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   | 17. INFORMANT<br><b>John Briggs, R. R. #4, St. Joseph, Mo.</b><br>Address _____  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  | 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<br><b>St. Joseph, Mo.</b><br>COUNTY _____ STATE _____   |
| 21. I attended the deceased <b>on February 1, 1962</b> and last saw <b>him</b> live on <b>2-1-62</b><br>Death occurred at <b>11:45 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   | 22a. SIGNATURE<br><b>D. E. Sklenar</b> (Degree or title)<br>22b. ADDRESS<br><b>1218 N. 3.; St. Joseph, Mo.</b><br>22c. DATE SIGNED<br><b>2-5-62</b>         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  | 23b. DATE<br><b>2/2/1962</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springfield</b>  | 23d. LOCATION (City, town, or county)<br><b>Mo.</b>  |
| 24. FUNERAL DIRECTOR<br><b>Heaton-Bowman</b>   | ADDRESS<br><b>St. Joseph, Mo.</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>Feb. 7, 1962</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Standell</b>  |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **Dr. Sklenar, M.D.** MEDICAL CERTIFICATION

FEB 15 1962

**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 Ernest Wood

Licensed Embalmer No. 3804  
P. O. Address 314 South Main

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.