

AUG 23 1935

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

24273

## 1. PLACE OF DEATH

County *St. Louis*Registration District No. *788*Township *Webster*Primary Registration District No. *7421*City *Forest*(No. *746 North Forest*)

File No. \_\_\_\_\_

Registered No. *79*

St. \_\_\_\_\_

Ward \_\_\_\_\_

2. FULL NAME *John Hensford Higdon*(a) Residence, No. *746 Forest Ave*

(Usual place of abode)

St. \_\_\_\_\_

Ward. \_\_\_\_\_

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *23* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary E Higdon</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>May 20 1865</i>		
7. AGE	YEARS <i>70</i>	MONTHS <i>2</i>
	DAYS <i>2</i>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Clerk St. Louis Court House</i>	11. Total time (years) spent in this occupation _____
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Retired 20</i>	
	10. Date deceased last worked at this occupation (month and year) _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Rockport Arkansas</i>		
FATHER	13. NAME <i>John R Higdon</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Georgia</i>	
MOTHER	15. MAIDEN NAME <i>Maney Bollinger</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>	
17. INFORMANT (ADDRESS) <i>Grace M. Higdon 746 N Forest Ave</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Hiram Cemetery</i> DATE <i>July 23 1935</i>		
19. UNDERTAKER (ADDRESS) <i>Parker Dead Co Webster Groves Mo</i>		
20. FILED <i>7-22-35</i> <i>Julius A. York</i> Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 20 1935*

22. I HEREBY CERTIFY That I attended deceased from *July 19 1935* to *July 20 1935*

I last saw him alive on *July 19 1935* Death is said to have occurred on the date stated above, at *7:05* a.m.

The principal cause of death and related causes of importance were as follows:  
*Acute Cardiac Dilatation*

Other contributory causes of importance:  
*Acute Indigestion*  
*Unusual exertion climbing tree*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify \_\_\_\_\_

(Signed) *Wm E. Barker* M. D.  
(Address) *802 Atlanta Mobile Groves Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH OMISSIONS

Printed in Great Britain

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. <sup>1</sup>Extra statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENT. <sup>Do not use this space.</sup>

1. PLACE OF DEATH

County St. Louis  
Township  
City Westminster (No. \_\_\_\_\_)

Registration District No. 788  
Primary Registration District No. 4471

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

John Hensford Higdon  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
70 2 \_\_\_\_\_

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER FATHER  
13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 11-5- 1935 Jules K. Yore Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20, 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Acute Cardiac de-  
lusion under strain  
Chronic Myocarditis  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) Wm S. Barker M. D.  
(Address) 802 Atlantic Webster Groves

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