

REC'D MAY 17 1938

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

15043

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township _____ Primary Registration District No. 1767 Registered No. _____
(c) City Linn (d) Street No. Miller Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Miss Marie Louise Higgins 2521
(a) Residence, No. Linn State Park Rd. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Carrie Young</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 25 1863</u>		
7. AGE <u>75</u>	YEARS	MONTHS <u>1</u>
		DAYS <u>25</u>
		IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as 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) <u>St Clair Co Mo</u>		
FATHER	13. NAME <u>William Tiffin Higgins</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>	
MOTHER	15. MAIDEN NAME <u>Elyzabeth Blen</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>	
17. INFORMANT (ADDRESS) <u>Carrie Young</u> <u>Linn State Park Rd.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Red Mo</u> DATE <u>April 20 1938</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Palmer</u> <u>Linn State Park</u>		
20. FILED <u>4-20</u> 19 <u>38</u> <u>J. A. McCamb</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 19 1938

22. I HEREBY CERTIFY, That I attended deceased from Apr 18, 1938, to Apr 19, 1938
I last saw him alive on Apr 19, 1938. Death is said to have occurred on the date stated above, at 11 P.m.
The principal cause of death and related causes of importance were as follows:
Fracture skull Date of onset 4-18-38

Other contributory causes of importance: 175
Hemorrhage

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? homicide Date of injury 4-18, 1938
Where did injury occur? Laclede Co Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
at home

Manner of injury _____
Nature of injury Fracture skull

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) N. A. Hamilton, M. D.
(Address) Linn State Park, Mo.

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STATEMENT BY LICENSED EMBALMER

I, Rabahn, Licensed Embalmer No. 1161

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by Registered Apprentice No.
working under my personal supervision.

Signed Rabahn
Licensed Embalmer No. 1161

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.)

CVU... PASIA... of... spot apoung de ceterijia embu...

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

15-043
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township _____ Primary Registration District No. 4267 Registered No. _____
(c) City Lebanon (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sheildan Higgins
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
75 1 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____, 19____

I last saw him 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:

Fractured skull Date of onset _____

struck on head by some

Other contributory causes of importance: Hemorrhage 1938

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 homicide Date of injury 4-18, 1938

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) H. A. Hamilton, M. D.

(Address) Lebanon Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CUSTOMERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTAL

