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.

REC'D MAY 18 1939

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

Do not use this space.

1. PLACE OF DEATH
County Adair — Registration District No. 4 — File No. 14087
Township — Primary Registration District No. 3001 — Registered No. 116
City Kirksville (No. Laughlin Hospital St. Ward)

2. FULL NAME Rose Mary Higgins
(a) Residence, No. St., Ward. Green Castle, Mo.
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 31, 1937
7. AGE: YEARS 2 — MONTHS 3 — DAYS 9 — If LESS than 1 day, hrs. or min.

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. Child.
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) Grun City Missouri

FATHER
13. NAME William Higgins
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER
15. MAIDEN NAME Reta Moats
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) W. J. Higgins Grun Castle, Missouri
18. BURIAL, CREMATION, OR REMOVAL
PLACE Grun Castle Cem. DATE May 11 1939
19. UNDERTAKER (ADDRESS) Glenn E. Kent & Son Grun City, Mo.
20. FILED May 9 1939 Spencer L. Freeman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9, 1939
22. I HEREBY CERTIFY, That I attended deceased from ~~April~~ 30, 1939, to ~~April~~ May 9, 1939
I last saw her alive on ~~April~~ May 9, 1939. Death is said to have occurred on the date stated above, at 5:00 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Post diphtheratic paralysis of muscles of throat associated with paralysis of arms & legs	

Other contributory causes of importance:

10

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) W. M. H. Graves, M. D.
(Address) Laughlin Hospital Kirksville, Mo.

RECEIVED
District Health Officer No. 10
District File Number 10-39-765
Date Filed MAY 16 1939