

Registration District No. 1000

Primary Registration District No. _____

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
At Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 4166 Shenandoah Ave (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mollie Higgins 2521

3. (b) If veteran, name war *** 3. (c) Social Security No. ***

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 24, 1870
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>69</u>	<u>3</u>	<u>16</u>	hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

12. Name Edward Higgins 5

13. Birthplace Ireland 5
(City, town, or county) (State or foreign country)

14. Maiden name Hannah Sweeney
(City, town, or county) (State or foreign country)

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edward Higgins

(b) Address 4166 Shenandoah Ave

17. (a) Burial (b) Date thereof Oct 13 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) OCT 11 1939 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 4166 Shenandoah Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10th
 year 1939 hour 12:00 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from 1937
 _____, 19____, to Oct 10, 19____
 that I last saw her alive on 10-9-39, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10.2.39

Due to Arterio-Sclerous

Due to Senility

Other conditions Hypertension
(Include pregnancy within 3 months of death)
Stiffening

Major findings: Of operations _____

Of autopsy no 820

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature Dr. Peetz (M. D. or other) _____
 Address Peetz Brothers Date signed 10.11.39

WHILE FILLING IN USE UNWRAPPING BLACK INK—MAKE A PERMANENT RECORD

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.

Dr. Seibold
Carelton Bldg.
Gar 0070

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Manuel Owens

Licensed Embalmer No.

2245

P. O. Address.....

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 this body is not embalmed, above space should be left blank.