

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

DEC 18 1939

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

41016
Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan 2 Registration District No. 847
 (b) Township Keosauqua 1 Primary Registration District No. 6112 Registered No. 16
 (c) City Green City (d) Street No. 135111 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 Frances Kay Higgins

(a) Residence, No. _____ St. 1 (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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-20-39

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, <u>X</u> hrs. or _____ min.
<u>X</u>	<u>X</u>	<u>X</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. X

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) Green City (STATE OR COUNTRY) Mo.

FATHER

13. NAME Claude Higgins
 14. BIRTHPLACE (CITY OR TOWN) Linnville (STATE OR COUNTRY) Iowa

MOTHER

15. MAIDEN NAME Irene Quist
 16. BIRTHPLACE (CITY OR TOWN) Green Castle (STATE OR COUNTRY) Mo.

17. INFORMANT Claude Higgins (ADDRESS) Green City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Olivet DATE 11-21 1939

19. FUNERAL DIRECTOR (NAME) Glenn E. Hunt (ADDRESS) Green City Mo.

20. FILED Nov 30 1939 Virginia Gibson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-20 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 20 1939 to Nov 20 1939

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:

This baby was bonded Unknown Cause. Labor was not hard

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) W. H. Knight M.D. M. D.

(Address) Green City Mo

RECEIVED

District Health Officer No. 10

District File Number 12-39-2071

Date Filed DEC 5 1939

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.....

Licensed Embalmer No.....

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.