

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
Kansas City
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community **16 yrs**
years, months or days)

3. (a) PRINT FULL NAME **THOMAS J. HIGGINS** **252**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **487-16-6286**

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

6. (b) Name of husband or wife **Mrs Edna A. Higgins** 6. (c) Age of husband or wife if alive **33** years

7. Birth date of deceased **Mar 18 1877**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 1 17 hr. min.

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

10. Usual occupation **RE-ASSESSOR** County **Jackson**

11. Industry or business **Jackson County** **5**

12. Name **Patrick Higgins**

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

14. Maiden name **Ella O'Day**

15. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edna A. Higgins**

(b) Address **700 Spruce**

17. (a) **Removal** (b) Date thereof **June 16 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pittsburg Kansas**

18. (a) Signature of funeral director **Mrs. C.L. Forster**
918 Brooklyn Kansas City Mo.

(b) Address

19. (a) **June 16, 1940** (b) **M.M. Craue**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits write "RURAL")
(d) Street No. **700 Spruce**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **15th**
year **1940** hour **9** minute **20** A. M.

21. I hereby certify that I attended the deceased from **June 14th 1940** to **June 15th, 1940**;
that I last saw him alive on **June 15th, 1940**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death:
Diabetes Mellitus (Clin.)
acidosis
Pulmonary Cong **54**
and edema.

Other conditions **Encephalomalacia - Temp**
(Include pregnancy within 3 months of death) **Label**

Major findings:
Of operations _____
Of autopsy _____

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)
(e) Means of injury _____

23. Signature **P. J. DeMara M.D.** (M. D. or other)
Supt. K.C. Gen. Hospital, K.C. Mo.
Address _____ Date signed _____

Duration
54
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Denzil E. Browning*

Licensed Embalmer No. *2724*

P. O. Address *R. E. Mo*

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.