

Registration District No. 460

Primary Registration District No. 5623

Registrar's No. 35

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Higginsville Mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Higginsville - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 2 Mile North Higginsville
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Lydia Alma C. Minnich Hagan
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 May 3 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____
12. Name Arma Minnich Hagan
13. Birthplace Marshallville Mo
(City, town, or county) (State or foreign country)
14. Maiden name Arma Richmond
15. Birthplace Marshallville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address _____
17. (a) Burial (b) Date thereof July 16 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Eng. Cemetery
18. (a) Signature of funeral director Roger W. Minnich
(b) Address Higginsville Mo
19. (a) 7-27-40 (b) W. J. Webb
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1940 hour 8:30 minute _____ P.M.
21. I hereby certify that I attended the deceased from July 1935
_____, 19, to July 1940, 1940
that I last saw him alive on July 9th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
Coronary Fibriillation Duration 3 years
Paroxysmal Tachycardia 30 years

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy _____
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? No
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Eugene M. Webb (M. D. or other) _____
Address Higginsville Mo Date signed 7-15-40

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.

RECEIVED
District Health Officer No. 8,
Transfer File Number 8-5-48
Date Filed

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 *Roy F. Wiegman*
Licensed Embalmer No. *2883*
P. O. Address *Higginville*

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.