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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34058 3998

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

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

48
3
8

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2427 Montgall
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether
In this community 65 yrs. /
years, months or days)

2. USUAL RESIDENCE OF DECEASED: .048 3 8

(a) State Mo (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2106 Summit St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME WILLIAM HIGGINS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced 2

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 1 (Month) 21 (Day) 1876 (Year)

8. AGE: Years 65 Months 9 Days 4 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John S. Higgins, Ill.
13. Birthplace Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Whitmore I
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Cora Kee

(b) Address 2106 Summitt St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/41 Maple Hill K. C. K. (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cem. K. C. K.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 10/27/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 10-25-41
year hour minute 10:00 A. M.

21. I hereby certify that I attended the deceased from 10-9 Cancer, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Deputy Coroner

Duration

Hemopericardium 36 D

Due to Rupture of the aorta

Due to Syphilitic aortitis c̄ aneurysm

Other conditions
(Include pregnancy within 3 months of death)
Of ascending aorta

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) 3

Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.