No. 2
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17-39
K32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1943

Registration District No. 189

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14859

State File No.

Primary Registration District No. 3043

Registrar's No. 68

1. PLACE OF DEATH:

(a) County: Marion

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

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

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: Pike

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

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

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3. (a) PRINT FULL NAME: Higgins, William

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mrs. Anna Higgins

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: Jan. (Month) 15 (Day) 1869 (Year)

8. AGE: Years 74 | Months 1 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace: Kinderhook (City, town, or county) Ill (State or foreign country) 1

10. Usual occupation: Farmer

11. Industry or business .....

FATHER
12. Name: John Higgins
13. Birthplace: Ireland (City, town, or county) (State or foreign country) 4

MOTHER
14. Maiden name: Anna Linton
15. Birthplace: Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant: Floyd Higgins
(b) Address: Kinderhook Ill

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3-5-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Kinderhook Ill

18. (a) Signature of funeral director: Thos. N. Lail
(b) Address: Barry, Ill

19. (a) 3-4-43 (Date received local registrar) (b) R. H. Connor (Registrar's signature)

1144

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 3 year: 1943 hour: 4 minute: 45 P.M.

21. I hereby certify that I attended the deceased from 2-23 1943 to 3-2-43 1943; that I last saw him alive on 3-2-43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal Pneumonia	5 Days
Due to: Hypertensive Cardio-Vascular Disease	2 yrs?
Due to: Cerebral Arteriosclerosis	2 yrs
Due to: Cerebral Hemorrhage	2 wks
Other conditions (Include pregnancy within 3 months of death)	

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

23. Signature: Francis E. Sultzman (M. D. or other) MD
Address: Hannibal Mo. Date signed: 3/4/43

(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 with the above constitutes grounds for revocation of license.)

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

S. No. 2B
1—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14859

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 68

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: Levering Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 7 da. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Pike

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

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME William Higgins

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Jan. (Month) 15 (Day) 1869 (Year)

8. AGE: Years 74 Months 1 Days 18 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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

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

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day ..... year 1943 hour ..... minute ..... M.

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

	Duration
Immediate cause of death Terminal Bronchial Pneumonia ✓	5 da.
Due to Hypertensive Cardio-vascular Disease	2 yr.
Due to Cerebral arteriosclerosis	2 yr.
Cerebral Hemorrhage	2 yr.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy 107

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 L. E. Sultzman (M. D. or other) MD
Address Hannibal Mo Date signed .....

S-14859