

Registration District No. 818 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS
(c) Name of hospital or institution: St. Anthony's Hosp. 0
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Higgs
3. (b) If veteran, name war no
3. (c) Social Security No. 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 March 29 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day hr. min.

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business
MOTHER FATHER {
12. Name Frank Higgs
13. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Opal Sparks
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Higgs
(b) Address 2720 S. 13th St. 40 W. 9/31/45
17. (a) Burial (b) Date thereof 3-31-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director Witt B. L. ...
(b) Address 2820 S. Jefferson Av.
19. (a) MAR 31 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town ST. LOUIS 17 023
(If outside city or town limits, write "RURAL")
(d) Street No. 2720 S. 13th St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 30
year 1945 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from 3/29
1945, to 3/30, 1945
that I last saw her alive on 3/30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Rupture of membranes
Due to 6 months gestation
Due to C
Other conditions 160
(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 William K. Proeda (M. D. or other) med
Address 1225 Sidney Date signed 3/31/45

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.....

not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed *Edgar F. Witt*.....

Licensed Embalmer No. *2117*.....

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.