

FILED OCT 23 1945

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

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: Kansas City Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Six Months
(Specify whether
In this community unknown
years, months or days)

3. (a) PRINT FULL NAME

John Hignutt

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 5. Color or race W 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 July 2 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

FATHER { 12. Name John Hignutt
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Mattie Blaine
15. Birthplace Ray County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Mason
(b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof Oct. 9, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brahsar Cem.

18. (a) Signature of funeral director Brathens - Ford
(b) Address Orrick, Mo.

19. (a) 10-13-45 (b) Geraldine Holmea
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2523 Walnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1945 hour 2:00 minute _____ M.

21. I hereby certify that I attended the deceased from 12-14-43
to 10-6-45
that I last saw her alive on 10-6-45
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Arteriosclerosis

Due to _____

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

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? _____
(Specify type of place) (e) Means of injury _____

23. Signature W Lawrence (M. D. or other)
Address 3200 North 2nd Date signed 10-6-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. B. Brathers

Licensed Embalmer No. 2001

P. O. Address Richmond, 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, fact should be so stated above.