

FILED FEB 20 1946  
318

STANDARD CERTIFICATE OF DEATH

State File No. 7545  
1370  
Registrar's No.

Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4475 West Pine Blvd./  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
in this community 50 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4475 West Pine Bl  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

John Patrick 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 Married  
6. (b) Name of husband or wife Maude Higgins  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 19th, 1873  
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Higgins Cross, Ireland.  
(City, town, or county) (State or foreign country)

10. Usual occupation Regional Representative

11. Industry or business American Water Way

MOTHER FATHER {  
12. Name John Higgins  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Ann O'Dea  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maude Harvey Higgins  
(b) Address Hawthorn Apt. 1101

17. (a) Removal (b) Date thereof 2-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chicago Illinois

18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 3840 Lindell Blvd

19. (a) FEB 10 1946 (b) J. F. Brueck  
(Bureau or local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8th  
year 1946 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from many years  
\_\_\_\_\_, 19\_\_\_\_ to Feb. 8, 1946  
that I last saw him alive on Feb. 8, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure  
Due to Coronary thrombosis  
with infarction  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 5 months of death)

Duration 6 mos.  
6 mo  
ago  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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?  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury 5  
23. Signature Walter Luten (M. D. or other) \_\_\_\_\_  
Address St. Louis Mo Date signed 2-9-46

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

3720 W. Wash St  
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**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 W Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.**