

FILED JUN 13 1946
Registration District No. 170

Primary Registration District No. 5704

16179 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Livingston
 (b) City or town Wheeling
 (c) Name of hospital or institution: XXXX
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XXX
 In this community 66 yrs.
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Livingston
 (c) City or town Wheeling
 (d) Street No. XXX
 (e) Citizen of foreign country? No
 If yes, name country XX

3. (a) PRINT FULL NAME Emma E. Higgins
 3. (b) If veteran, name war XXX
 3. (c) Social Security No. XXX

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 17
 year 1946 hour 5 minute A.M.
 21. I hereby certify that I attended the deceased from May 12
1946 to May 17 1946
 that I last saw her alive on May 17
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Paul Higgins
 6. (c) Age of husband or wife if alive Deceased
 7. Birth date of deceased March 28 1874
 (Month) (Day) (Year)

Immediate cause of death Myocarditis
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>2</u>	<u>19</u>	<u>X</u> hr. <u>X</u> min.

Major findings: Of operations
 Of autopsy _____
 PHYSICIAN A. B. [Signature]
 Underline the cause to which death should be charged statistically.

9. Birthplace Roseville Illinois
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife
 11. Industry or business XX
 12. Name Aaron Powers
 13. Birthplace XX Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Nubern
 15. Birthplace XX Pa
 (City, town, or county) (State or foreign country)

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)
 (e) Means of injury _____
 23. Signature [Signature] Date signed 7/18/46
 Address Wheeling, Mo.

16. (a) Informant Mrs. Jack Love
 (b) Address Wheeling, Mo.
 17. (a) Burial (b) Date thereof 5/19/46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wheeling, Mo.
 18. (a) Signature of funeral director [Signature]
 (b) Address Chillicothe, Mo.
 19. (a) 5/18/46 (b) Mrs. Bertha Boone
 (Date received local registrar) (Registrar's signature)

JUL 23 1945

JUN 24 1945

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Ronald F. Gordon*

Licensed Embalmer No. *4191*

P. O. Address *Phillips, 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.