

FILED MAY 21 1946

Registration District No. **297**

Primary Registration District No. **3056**

Registrar's No. **92**

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **Moberly**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Wabash Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Randolph**
(c) City or town **Moberly**
(If outside city or town limits, write "RURAL")
(d) Street No. **625 FISK AVE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Maurice Higgins**
3. (b) If veteran, name war
3. (c) Social Security No. **703-01-2408**

4. Sex **male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Bertha** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 15 1880**
(Month) (Day) (Year)

8. AGE: Years **65** Months **7** Days **20** If less than one day hr. min.

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

10. Usual occupation **Conductor**

11. Industry or business **Wabash R.R.**

12. Name **Timothy Higgins**

13. Birthplace **Mass**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Moriarty**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Bertha Higgins**

(b) Address **Moberly, Mo**

17. (a) **Burial** (b) Date thereof **Apr 23 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moberly, Mo**

18. (a) Signature of funeral director **Mahan and Son**

(b) Address **Moberly, Mo**

19. (a) **Apr 23-46** (b) **Seah Nuttall-Covey**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **21st** year **1946** hour **10** minute _____ A.M.
21. I hereby certify that I attended the deceased from **6 March** 19**46** to **21 April** 19**46** that I last saw him alive on **21 April** 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cardiac Failure
Malignant Hypertension
Due to **Myocarditis, chronic**
Atherosclerosis, chronic gen. pars.
Due to **Nephritis, Chronic Interstitial**
Other conditions (include pregnancy within 3 months of death) _____

Duration
24 hours
60 days
7 year
1 year

Major findings: Of operations **None**
Of autopsy **None**
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 plant) (e) Means of injury _____
23. Signature **A. [Signature]** (M. D. or other) **no**
Address **Wabash Hospital** Date signed **Apr 23 1946**

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

JUN 8 1946

SEP 21 1946

MAY 27 1946

RECEIVED
District Health Officer No. 10
District File Number 5-46-927
Date Filed MAY 20 1946

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 Frank B. S. Wilt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Mabel
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Maurice 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 Sept 1901 (Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace South West Ohio (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Apr 23-46 (b) Paul William Price (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April Year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER, FATHER

13880

17762

APRIL 1 1962