

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27716**  
Registrar's No. **91**

Registration District No. **200** Primary Registration District No. **5725**

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

1. PLACE OF DEATH:  
(a) County **Macon**  
(b) City or town **rural Hudson**  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(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 **Maggie May, Luqua**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **widow**  
6. (b) Name of husband or wife **William L. Higgins** 6. (c) Age of husband or wife if alive  years  
7. Birth date of deceased **June 21, 1875**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **1** Days **3** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **house wife**

11. Industry or business \_\_\_\_\_

12. Name **Phillip Hawk**

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

14. Maiden name **Sarah Parison**

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

16. (a) Informant **Mr. Kenneth King**  
(b) Address **Macon, Mo.**

17. (a) **Buried** (b) Date thereof **7-26-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Breakfield Cem.**

18. (a) Signature of funeral director **Stephen Gooding**  
(b) Address **Macon, Mo.**

19. (a) **8/30/46** (b) **Beth McNeely**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Macon**  
(c) City or town **rural**  
(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 **July** day **24** year **1946** hour **19** minute **05** A.M.  
21. I hereby certify that I attended the deceased from **24** to **26** July 1946  
that I last saw him/her alive on **July 24, 1946** and that death occurred on the date and hour stated above.  
Duration \_\_\_\_\_

Immediate cause of death **Coronary thrombosis 1 day**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
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) (e) Means of injury \_\_\_\_\_  
23. Signature **D. L. Hulan** (M.D. or other) **in O**  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

26554

RECEIVED

District Health Officer No. 10  
District File Number 9-46-1646  
Date Filed SEP 7 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..... *C. L. Stephens* .....

Licensed Embalmer No. *3057* .....

P. O. Address *Macon, 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.