

FILED JUN 10 1947

Registration District No. 47

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3008

State File No. 16717

Registrar's No. 206

1. PLACE OF DEATH:

(a) County CALLAWAY
(b) City or town FULTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CALLAWAY HOSPITAL
(If not in hospital of institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
(Specify whether years, months or days)
In this community 2 YRS. 10 Mo.

3. (a) PRINT FULL NAME ROBERTA V. HIGGINS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife B.F. Higgins 6. (c) Age of husband or wife if alive DECEASED years
7. Birth date of deceased Dec. 31 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 2 If less than one day
hr. min.

9. Birthplace DK. ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
12. Name John SCHUMAKER
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name JANE OSBORNE
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS J.A. LAY
(b) Address MCCREDIE, MO
17. (a) BURIAL (b) Date thereof June 4, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VALHALLA St. Louis Co.

18. (a) Signature of funeral director Glen G. Maupin
(b) Address 712 Court Fulton, Mo
19. (a) 6-3-47 (b) Josie Morankoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. MCCREDIE, MO
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1947 hour 1 minute XXA.M.

21. I hereby certify that I attended the deceased from May 29 1947, to Death 1947
that I last saw her alive on June 1 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomposition Duration 2 days

Due to _____
Due to _____

Other conditions Cerebral Hemorrhage 4 days
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 95 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? _____
(Specify type of place) (e) Means of injury _____

While at work? _____
Signature: Josie Morankoff (M. D. or other) MD
Address Fulton, Mo Date signed 6-2-47

WRITE PLAINLY—USE ONLY INK

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed JUN 9 1947

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 Glen Y. Maupin
Licensed Embalmer No. 2725
P. O. Address Fulton, 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. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Fulton
(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 Roberta D. Higgins
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased see 3/
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____
(If less than one day)
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) June 3 1947 (b) Joan Morantoff
(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 _____
 year 1947 month _____ minute _____ M. _____
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her 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)
 (e) Means of injury _____

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

SUPPLEMENTARY

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

100717