

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35417**

FILED NOV 5 1947

Registration District No. **311**Primary Registration District No. **4456**Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **St Clair**
(b) City or town **Appleton City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home 1**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whetherIn this community **80 yrs.**
years, months or days)3. (a) PRINT FULL NAME **Louisa Jane Higgins**3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**4. Sex **Fem** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Gibbert A Higgins** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb 1861**
(Month) (Day) (Year)8. AGE: Years **86** Months **7** Days **26** If less than one day _____ hr. _____ min.9. Birthplace **Milford Indiana**
(City, town, or county) (State or foreign country)10. Usual occupation **Housekeeping**

11. Industry or business

MOTHER FATHER { 12. Name **Thomas Frisby** 13. Birthplace **England**
{ 14. Maiden name **Larva Bean** 15. Birthplace **Penn**
{ (City, town, or county) (State or foreign country)16. (a) Informant **Maggie Patterson**(b) Address **Appleton City Mo**17. (a) **burial** (b) Date thereof **Oct 19 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Kidds Chapel**18. (a) Signature of funeral director **Frank Eber**(b) Address **Appleton City Mo**19. (a) **Oct 17-47** (b) **Miss Cleo Abney**
(Date received local registrar) (Registrar's signature) **2/25**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Clair 93**
(c) City or town **Appleton City Mo**
(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 **Oct** day **15**
year **1947** hour **10** minute **10 P** M.21. I hereby certify that I attended the deceased from **1 Sept**
_____ 1947, to **15 Oct** _____ 1947,
that I last saw her alive on **15 Oct** _____ 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to **Benign hypertension**
ArteriosclerosisDue to _____
Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____
Of autopsy _____
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 place) (e) Means of injury **0**23. Signature **Edmouise MD** (M.D. or other) _____
Address **Appleton City, Mo** Date signed **17 Oct 47**

RECEIVED
Dist. of Health Officer No. 2,
Certificate No. 10-42-1278
Date Paid 11-7-47

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
on the 16th day of Oct 1947, Registered Apprentice No. _____
working under my personal supervision.

Signed Frank Linn

Licensed Embalmer No. 1099

P. O. Address Appleton City 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.