

DR. JOHN FORGRAVE
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40933

State File No. _____

FILED JAN 5 1948

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1519

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
MISSOURI METHODIST 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 DAYS
13 DAYS (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County ATCHISON 997

(c) City or town EFFINGHAM RURAL
(If outside city or town limits, write "RURAL") 13

(d) Street No. R.F.D. NO. 2
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME GEORGE NEWTON HIGLEY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE 0 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MARY ELIZABETH BROCKMAN HIGLEY years _____

6. (c) Age of husband or wife if _____ years

7. Birth date of deceased JAN. 3, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

<input checked="" type="checkbox"/>	73	11	21	hr.	min.
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9. Birthplace CUMMINGS, KANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business _____

12. Name ROSSELL HIGLEY

13. Birthplace UNKNOWN ILLINOIS
(City, town, or county) (State or foreign country)

14. Maiden name MARY ELIZABETH MARION

15. Birthplace UNKNOWN MASS.
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. SIMPSON BROWN

(b) Address ST. JOSEPH, MO.

17. (a) REMOVAL (b) Date thereof 12-24-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CUMMINGS, KANSAS

18. (a) Signature of funeral director Wm. Stantini

(b) Address ATCHISON, KANSAS

19. (a) 12-29-47 (b) E. G. Jenkins
(Date received local registrar) (Registrar's signature) 257

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 24
year 1947 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec -11-47
21 1947 to Dec 24 - 1947
that I last saw him alive on Dec 23 - 47 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism 5 min

Due to Apoplexy absc.

Due to _____

Other conditions 121
(Include pregnancy within 3 months of death)

Major findings: Ruptured Aneurysm

Of operations _____

Of autopsy _____

Duration

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 Paul Forgrave (M. D. or other)

Address ST Joseph Mo Date signed 12-26-47

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

MOTHER FATHER

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..... *Wm. S. Carter, Jr.*.....

Licensed Embalmer No. *3778*.....

P. O. Address.....

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.