

FILED JAN 6 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41358**

Registration District No. **120**

Primary Registration District No. **4196**

Registrar's No. **106**

1. PLACE OF DEATH:

(a) County Sentry
(b) City or town Carlington
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Lifelong
years, months or days

3. (a) PRINT FULL NAME James Franklin Higgins

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased April 20 - 1870
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Sentry Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Stitch labourer

11. Industry or business _____

12. Name Mary B. Higgins

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

14. Maiden name York

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

16. (a) Informant's own signature family records
(b) Address _____

17. (a) Burial (b) Date thereof 12-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville

18. (a) Signature of funeral director W. H. ...
(b) Address Albany Mo

19. Dec 27 - 1947 (b) Harold W. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sentry
(c) City or town Carlington
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5
year 1947 hour 9 minute 4 M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 Pectoral Angina Duration Three
found dead at his home.

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 946 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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____
23. Signature Charles W. ... (M. D. or other) ...
Address Sentry Mo Date signed 12-10-47

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. Clifford Burka

Licensed Embalmer No.

3329

P. O. Address

Albany 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, above space should be left blank.