

No. 2
-12-45
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5763

State File No. _____

FILED MAR 6 1948

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County PIKE

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

(c) Name of hospital or institution:
MINERAL SPRING HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 DAYS
77-6-16 (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PIKE

(c) City or town CYRENE Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 2 North of Cyrene
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM ROBERT HIGGIN

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife Martha Higgins

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased July 19-1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>6</u>	<u>16</u>	hr. min.

9. Birthplace 2 Mi. North of Cyrene Mo. U
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Wm R. Higgins Sr.

13. Birthplace England

14. Maiden name Eliza Colfield

15. Birthplace England

16. (a) Informant Mrs Martha Higgins

(b) Address Bowling Green

17. (a) Burial (b) Date thereof 2-4-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation antioch Cem

18. (a) Signature of funeral director W. B. E. C. Moore

(b) Address Bowling Green

19. (a) 2/4/48 (b) Bernice Collier
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 2
year 1948 hour H minute 35 P.M.

21. I hereby certify that I attended the deceased from JANUARY 29, 1948 to FEB 2, 1948
that I last saw her alive on FEB. 2, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis Duration 2 weeks

Due to _____

Due to _____

Other conditions Prostatitis - meningitis Unknown
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 92 E

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 2

23. Signature W. B. E. C. Moore (M. D. or other) MO

Address LOUISIANA MO Date signed FEB 2, 1948

RECEIVED
District Health Officer No. 10
District File Number 348430
Date Filed MAR 4 1948

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 W. B. Priore
Licensed Embalmer No. 3466
P. O. Address Bowling Green

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.