

FILED MAR 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9509

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana	
d. FULL NAME OF HOSPITAL OR INSTITUTION 514 Alabama St.		d. STREET ADDRESS (If rural, give location) 514 Alabama St.	
3. NAME OF DECEASED (Type or Print) a. (First) TOM		b. (Middle) HIGGINS	
c. (Last) HIGGINS		4. DATE OF DEATH (Month) (Day) (Year) March 8 1949	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/27/1880
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur, Janitor	11. BIRTHPLACE (State or foreign country) Louisiana Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Joe Higgins.	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Joe Higgins, 1015 Texas St. Louisiana Mo		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from 3-8, 1949, to 3-9, 1949, that I last saw the deceased alive on 3-8, 1949, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. H. Johnson, M.D.		23b. ADDRESS Louisiana, Mo.	
23c. DATE SIGNED 3-8-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/10/1949	
24c. NAME OF CEMETERY OR CREMATORY River View		24d. LOCATION (City, town, or county) Louisiana - Missouri	
DATE REC'D BY LOCAL REG. 3-10-49		REGISTRAR'S SIGNATURE 374	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Garner & Sterne Louisiana Mo.	

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

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22

615
3-18-49

RECEIVED

District Health Officer No. 1

District File Number 3-49-50

Date Filed MAR. 18 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Harold G. Turner

Signed.....
Student Embalmer

Licensed Embalmer No. 3720

P. O. Address *Louisiana 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.