

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

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|---|-------------------------------|---|--|--|--|
| BIRTH NO. | | REG. DIST. NO. <u>137</u> | | PRIMARY REG. DIST. NO. <u>3023</u> Registrar's No. <u>201</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> b. CITY (If outside corporate limits, write RURAL and give town) <u>Clinton</u> c. LENGTH OF STAY (If this place) <u>8 hrs</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wetzel Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>Hermitage</u> d. STREET ADDRESS (If rural, give location) <u>Rural - 1 mi East</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Audrey</u> b. (Middle) <u>Olivia</u> c. (Last) <u>Higginbotham</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept - 1 - 1949</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH. <u>Nov. 21 - 1932</u> | 9. AGE (In years last birthday) <u>16</u> if UNDER 1 YEAR Months <u>11</u> Days <u>21</u> if UNDER 2 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (State or foreign country) <u>Ind. I</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>UNKNOWN BLAND</u> | | 13b. MOTHER'S MAIDEN NAME <u>Essie OLSON</u> | 14. NAME OF HUSBAND OR WIFE <u>Wayne Higginbotham</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>NO</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Wayne Higginbotham</u> ADDRESS <u>Hermitage 740</u> | | |
| 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. | | 19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Accidents (Car)</u> ANTECEDENT CAUSES <u>pleurisy for yrs</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>260X</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 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) m. | | 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 <u>Aug 31, 1949</u> to <u>Sept 1, 1949</u> that I last saw the deceased alive on <u>Sept 1, 1949</u> , and that death occurred at <u>1 A. M.</u> , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Sus J. W. R. D.D. 2</u> | | 23b. ADDRESS <u>Clinton Mo.</u> | | 23c. DATE SIGNED <u>9-1-49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>Sept</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>L. Gordon Cemetery</u> | |
| 24d. LOCATION (City, town, or county) <u>Prophetstown, Ill.</u> | | 24e. (State) <u>Ill.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Hays, Wheatland, Ill.</u> | |
| DATE REC'D BY LOCAL REG. <u>Sept. 1 - 49</u> | | REGISTRAR'S SIGNATURE <u>Florence Adair</u> | | 422 | |

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RECEIVED

District Health Officer No. 71

District File Number 8-49-1075

Date Filed 9-7-49

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.

Student _____
Student Embalmer

Signed Chas. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland, W.V.

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.