

FILED JUN 15 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15372

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 5336 Registrar's No. 54-41

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Dade</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Center twp</u> |  | c. LENGTH OF STAY (in this place) <u>54 years</u>  | c. CITY OR TOWN <u>Route #1 Greenfield</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1/2 mi East of Greenfield</u>                     |  | STREET ADDRESS (If rural, give location) <u>1/2 mi East of Greenfield</u>  |  |

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| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>John</u><br>b. (Middle) <u>Linville</u><br>c. (Last) <u>Higgins</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>June 7, 1954</u> |
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|                    |                               |   |                                      |   |   |   |
|--------------------|-------------------------------|---|--------------------------------------|---|---|---|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 7, 1874</u> | 9. AGE (In years last birthday) <u>80</u> | IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u> | IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u> |
|--------------------|-------------------------------|---|--------------------------------------|---|---|---|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Dade Co., Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>John W<sup>m</sup> Higgins</u> | 13b. MOTHER'S MAIDEN NAME <u>Nancy Grider</u> | 14. NAME OF HUSBAND OR WIFE <u>Lucy Mae Higgins</u> |
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|--|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. Mabel Poe; Greenfield, Mo.</u> |
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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mo</u> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Prostatic Hypertrophy</u> |  |   |
|   | DUE TO (c) <u>Degenerative Heart Disease</u>   |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   |

|                        |   |  |
|------------------------|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>610 X</u> | 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 4-5, 1954, to 6-7, 1954, that I last saw the deceased alive on 5-26, 1954, and that death occurred at 8:15 a. m., from the causes and on the date stated above.

|  |                                     |                                |
|--|-------------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Lee A. McLaughlin M.D.</u> (Degree or title) | 23b. ADDRESS <u>Greenfield, Mo.</u> | 23c. DATE SIGNED <u>6-9-54</u> |
|--|-------------------------------------|--------------------------------|

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|---|--------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>June 10, 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>6-9-54</u> | REGISTRAR'S SIGNATURE <u>J. C. Canada</u> | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>J. C. Canada, Greenfield, Mo.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

290  
1

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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.....  
Signature of Student Embalmer

Signed.....

*J. C. Canada*

Licensed Embalmer No. *419*

P. O. Address *Greenfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.