

No. 300
10.48

FILED DEC 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37913

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 3573

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY OR TOWN <u>Bonne Terre</u>		c. CITY OR TOWN <u>West River 2 West St.</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>		STREET ADDRESS (If rural, give location) <u>2 Union St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Paul</u>	b. (Middle) <u>Ray</u>	c. (Last) <u>Higgins</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. - 25 - 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White Cauc.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 3 - 1918</u>	9. AGE (In years last birthday) <u>37-7-23</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shovel operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Flat River, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Mr. Leo L. Higgins</u>	13b. MOTHER'S MAIDEN NAME <u>Maudie May Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Mr. Virginia Kay 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>495-18-0626</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Virginia Kay Higgins</u> ADDRESS <u>2 Union St. Flat River, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Hypertension</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>445X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Oct 7, 1955, to 11-25, 1955, that I last saw the deceased alive on 11-25, 1955, and that death occurred at 10:17A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. H. Appleberry M.D.</u>	23b. ADDRESS <u>Flat River MO</u>	23c. DATE SIGNED <u>11-28-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 28-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Mo</u>
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DATE REC'D BY LOCAL REG. <u>Nov. 28, 1955</u>	REGISTRAR'S SIGNATURE <u>Ether Redlaff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin W. Hood</u> ADDRESS <u>Flat River MO</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 7

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 *Alvin W Hood*.....

Licensed Embalmer No *2780*.....

P. O. Address *303 Crane Plaza*.....

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.