

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015111

STATE FILE NUMBER

3950

FILED MAY 6 1959

Registration District No. Primary Registration District No.

Registration No. 3950

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5263 Waterman | | d. STREET ADDRESS (If outside, give location) 5263 Waterman | |
| Length of stay in lb 17 Yrs. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last EARL HIGGINBOTHAM | | | 4. DATE OF DEATH Month Day Year April 20, 1959 | | |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 23, 1897 | 9. AGE (In years last birthday) 62 | 10. F UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer | 10b. KIND OF BUSINESS OR INDUSTRY retired | 11. BIRTHPLACE (City and state or country) Bernie, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Frank Higginbotham | 13b. MOTHER'S MAIDEN NAME Paralee Greathouse | 14. NAME OF HUSBAND OR WIFE Ida Higginbotham |
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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) Yes WW I | 16. SOCIAL SECURITY NO. 713 03 9128 | 17. INFORMANT Billy Higginbotham, 5263 Waterman | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> | | INTERVAL BETWEEN ONSET AND DEATH 30 min |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>Coronary arteriosclerotic Heart Disease</i> | 5 yrs |
| | DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i> | 8 YRS. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.1</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|---------------------------------------|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from <i>July 1958</i> to <i>April 2, 1959</i> and last saw her/him alive on <i>April 6, 1959</i> Death occurred at <i>6:00 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <i>John A. Carrier, M.D.</i> | (Degree or title) | 22b. ADDRESS <i>4401 HAMPTON-ST. LOUIS, MO.</i> | 22c. DATE SIGNED <i>4-7-59</i> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | 23b. DATE <i>4-22-59</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla</i> | 23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i> |
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| 24. FUNERAL DIRECTOR <i>McLaughlin Funeral Home, Inc.</i> | ADDRESS <i>2301 Lafayette, St. Louis, Mo.</i> | 25. DATE RECD. BY LOCAL REG. <i>APR 21 '59</i> | 26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Vertical, horizontal, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 James R. Chapman
Licensed Embalmer No. 4530
P. O. Address St Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
• If this body is not embalmed, fact should be so stated above.