

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031006**

**EILED VS SEP 8 1959**

317

Registration District No. \_\_\_\_\_

Primary Registration District No. 547

Registrar's No. 2343

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hgts.</u>	Length of stay in 1b <u>5 yrs.</u>	c. CITY OR TOWN <u>Overland</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>2223 Burns</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle _____ Last <u>Higgins</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26, 1887</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINING IAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	11. BIRTHPLACE (City and state or country) <u>Potosi Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>JOHN R. HIGGINS</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA CARRIGAN</u>		14. NAME OF HUSBAND OR WIFE <u>Killie B. Higgins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-16-9271</u>		17. INFORMANT Address <u>Killie B. Higgins 2223 Burns</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			<u>7 years</u>
DUE TO (c) <u>General arteriosclerosis</u>			<u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____	

20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <u>Nov 1958</u> to <u>Aug 29 1959</u> and last saw <sup>her</sup> him <u>live</u> on <u>Aug 29 1959</u> Death occurred at <u>1:15</u> <u>p</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>James C Redington M.D.</u>		22b. ADDRESS <u>950 Francis Place Clayton 5 Mo</u>		22c. DATE SIGNED <u>8-31-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	23d. LOCATION (City, town, or county) (State) <u>FLORISSANT MO</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Ortmann J. Home 9222 Lackland Overland</u>	25. DATE RECD. BY LOCAL REG. <u>8-31-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Munfley M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Sam Stepanovic, Student Embalmer No. 5  
working under my personal supervision.

Student Sam Stepanovic  
Signature of Student Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.