

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

**59-040108**

**FILED VS DEC 10 1959**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5215

UNDECEASED

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <u>Jackson</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in lb <u>25 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>3630 CHESTNUT</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>	
First <u>Clarice</u>	Middle <u>ELIZABETH</u>	Last <u>Higginbotham</u>	Month <u>10</u>	Day <u>28</u> Year <u>59</u>

<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1 29 03</u>	<b>9. AGE (last birthday)</b> <u>56yrs.</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>	<b>IF UNDER 24 HR</b> Hours <u>    </u> Min. <u>    </u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <u>MISSISSIPPI</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
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<b>13a. FATHER'S NAME</b> <u>JOHN FRANK RAI FORD</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>ROSE ELLA WALKER</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>CLYDE C. HIGGINBOTHAM</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	<b>16. SOCIAL SECURITY NO.</b> <u>487 26 7784</u>	<b>17. INFORMANT</b> <u>CLYDE C. HIGGINBOTHAM 3630 CHESTNUT</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>Cerbro - vascular hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral metastasis</u>	
	DUE TO (c)	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour <u>    </u> a.m. <u>    </u> p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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<b>21. I attended the deceased from</b> <u>10-11-1959</u> to <u>10-28-1959</u> and last saw her <u>alive</u> on <u>10-28-1959</u>
Death occurred at <u>5:35</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>Abraham Gelpin M.D.</u>	<b>22b. ADDRESS</b> <u>2400 Cherry Kansas City, Mo</u>	<b>22c. DATE SIGNED</b> <u>10-29-59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>OCT 30, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MEMORIAL PARK CEM</u>	<b>23d. LOCATION</b> (City, town, or county) <u>KANSAS CITY MO.</u>
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<b>24. FUNERAL DIRECTOR</b> <u>D. W. NEWCOMER'S SONS K. C. MO.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-30-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Minshall</u>
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DOCUMENT

BY AFFIDAVIT OF Abraham Gelpin Medical Certification

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albert H. Savage

Licensed Embalmer No. 4812

P. O. Address Wansboro

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.