

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-002532

FILED VS FEB 9 1961

Registration District No. 276

Primary Registration District No. 4410

Registrar's No. 8

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Phelps</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>Phelps</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. James</b>		c. CITY OR TOWN <b>ST. James</b>	
Length of stay in lb <b>30 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Soldiers Home Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>-</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Higgins</b>			4. DATE OF DEATH Month Day Year <b>Feb. 6. 1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-3-1891</b>
9. AGE (last birthday) <b>89</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Do Not Know</b>	
13b. MOTHER'S MAIDEN NAME <b>Do Not Know</b>		14. NAME OF HUSBAND OR WIFE <b>Virginia Higgins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes Spanish Amer. War</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Soldiers Home Office - St. James</b>		Address <b>St. James MO</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis Sudden</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/> NO <input checked="" 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 <b>Jan 16-53</b> <b>1:45 P.</b> and last saw him alive on <b>Feb 6-61</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree and title) <b>J. G. ... MD</b>		22b. ADDRESS <b>St. James, MO.</b>	22c. DATE SIGNED <b>2-7-61</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2-9-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETERS Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>Dr. E. Licklider - ST James, MO</b>		25. DATE RECD. BY LOCAL REG. <b>2-7-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth B. Powell</b>

1961

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

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Oral E. Lickleiter

Licensed Embalmer No. 3546

P. O. Address 27 Jimmy 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.