

Dr. Walterscheid  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-016793**

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 148

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 29 1963**

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Length of stay in 1b	c. CITY OR TOWN <b>Hannibal</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1820 Mill St.,</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>T.</b> Last <b>Higgins</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>21</b> Year <b>1963</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>Feb. 2, 1886</b>
9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driller-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Pike Co., Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Peter Higgins</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Hoskins</b>		14. NAME OF HUSBAND OR WIFE <b>Emiley Higgins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>Theodore Higgins, 1820 Mill St</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>Massive Gastro Intestinal Hemorrhage</b> DUE TO (b) <b>Hematuria due to anticoagulants</b> DUE TO (c) <b>Myocardial anoxia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral vessel insufficiency-Arteriosclerotic heart disease &amp; Carcinoma of prostate</b> PART III. If deceased was female was there a pregnancy in last 90 days <input checked="" 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 Month, Day, Year a.m. p.m.	
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 <b>Hannibal Marion Mo.</b>		COUNTY STATE	
21. I attended the deceased from <u>4/20/63</u> to <u>4/21/63</u> and last saw her/him alive on <u>4/21/63</u> Death occurred at <u>9:35 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. H. Walterscheid M.D.</b>		22b. ADDRESS <b>1209 Broadway, Hannibal Mo.</b>	
22c. DATE SIGNED <b>4/22/63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>Apr. 24, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Taylor Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Rockport, Illinois</b>		23e. STATE <b>Illinois</b>	
24. FUNERAL DIRECTOR <b>H.M.O'Donnell, Hannibal, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>April 23, 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Dr. E.M. Laska by Lillian M. Herman</b>			

USE BLACK INK OR TYPEWRITER RIBBON

**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 *A. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.

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*Donna J. ... 4/23/63*