

FILED FEB 9 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

3514

BIRTH NO. _____		REG. DIST. NO. <u>336</u>		PRIMARY REG. DIST. NO. <u>4494</u>		Registrar's No. <u>349</u>	
1. PLACE OF DEATH a. COUNTY <u>SHANNON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>SHANNON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WINONA</u>		c. LENGTH OF STAY (in this place) <u>134RS</u>		c. CITY OR TOWN <u>WINONA</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <u>1010</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Pressley</u> c. (Last) <u>Higginbotham</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 21-1956</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 2-1873</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>George Higginbotham</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH DYER</u>		14. NAME OF HUSBAND OR WIFE <u>Lottie Higginbotham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lottie Higginbotham WINONA, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Congestive Heart Failure</u> ANTECEDENT CAUSES <u>Rheumatic Infection</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4341</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>May 1954</u> , to <u>Jan 21, 1956</u> , that I last saw the deceased alive on <u>Jan 21, 1956</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C E Sharp</u> (Degree or title) <u>DO</u>				23b. ADDRESS <u>Winona Mo</u>		23c. DATE SIGNED <u>1-25-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-24-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		24d. LOCATION (City, town, or county) (State) <u>WINONA, MO.</u>		
DATE REC'D BY LOCAL REG. <u>2-6-56</u>		REGISTRAR'S SIGNATURE <u>Malcolm Dallen</u> <u>1447</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DUNCAN'S Mt. View, Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Joe P. Duncan*
Licensed Embalmer No. *432*
P. O. Address *Mt. View*

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.