

No. 2  
1-13-40  
-17-39  
X23159

Registration District No. **836** Primary Registration District No. **60984** Registrar's No. **47**

3  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County **Stoddard** (b) City or town **Botham**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) **2**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **Life** years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Stoddard**  
(c) City or town **Bural** (If outside city or town limits, write "RURAL")  
(d) Street No. **Year Bernie** (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **James Lawson Higginbotham**  
(b) If veteran name war **No** (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct** day **3**  
year **1940** hour **9** minute **14 P.M.**

4. Sex **Male** 5. Color or race **Wht**  
6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Pearl Enola** (c) Age of husband or wife if alive **54** years  
7. Birth date of deceased (Month) **Oct** (Day) **4** (Year) **1865**

21. I hereby certify that I attended the deceased from **April 10**, 19**39**, to **Oct 3**, 19**40**.  
that I last saw him alive on **Oct 3 - 1940** and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **0** Days **0** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebral Hemorrhage**  
Due to **Cerebral Hemorrhage**  
Due to **Arteriosclerosis**  
Other conditions (Include pregnancy within 3 months of death) **1/21**

9. Birthplace **Franklin Mo.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Retired**  
11. Industry or business **Real Estate Farming**  
12. Name **Francis M. Higginbotham**  
13. Birthplace **Unknown Ill.** (City, town, or county) (State or foreign country)  
14. Maiden name **Higginbotham Riddle**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **E. B. Higginbotham** (b) Address **Walden, Mo.**  
17. (a) **Burial** (b) Date thereof **Oct 5-40** (Month) (Day) (Year)  
(c) Place: burial or cremation **Bernie Mo.**  
18. (a) Signature of funeral director **J. Craig**  
(b) Address **Walden Mo.**  
19. (a) **10-12-40** (b) **dawna Hopkin** (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **803**  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **W. Groce** (M. D. or other) \_\_\_\_\_  
Address **Bernie Mo.** Date signed \_\_\_\_\_

RECEIVED

District Health Officer No.

District File Number 1140-16

Date Filed 11/8/40

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed..... V.H. Prang

Licensed Embalmer No. 2850

P. O. Address: Malden, M.

**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 this body is not embalmed, fact should be so stated above.**