

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31879**  
Registrar's No. **7979**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3027 Dickson</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Walter</b>		b. (Middle) _____		c. (Last) <b>Higgins</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>8 25 54</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>6-6-1889</b>	
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Lab.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Street Dept.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Miss.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unk.</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>		14. NAME OF HUSBAND OR WIFE <b>Hattie Higgins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-10-7676</b>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>Hattie Higgins 3027 Dickson</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Carcinoma of Prostate with Metastases</b> REMARKS: <b>REMARKS: DEGENERATED METASTATIC</b> ANTECEDENT CAUSES <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: _____ DUE TO (b) _____ DUE TO (c) _____ <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <b>NO</b>	
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) _____		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>177X</b>					
22. I hereby certify that I attended the deceased from <b>7-29</b> , 19 <b>54</b> , to <b>8-25</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>8-25</b> , 19 <b>54</b> , and that death occurred at <b>7:00 P. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Morris Abrams M.D.</b>				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>8-26-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-1-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		24d. LOCATION (City, town, or county) (State) <b>6571 St. Louis Ave</b>	
DATE REC'D BY LOCAL REG. <b>11G 30 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>J. McClendon 4535 Washington</b>			

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

MAY 5 1958

**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 *John K. Cunningham*

Licensed Embalmer No. 447

P. O. Address 4700 Ham

**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.