

ORIGINAL

STATE OF ILLINOIS

STATE NO. 2074897

MEDICAL CERTIFICATE OF DEATH

REGISTERED NUMBER 176

1. NAME OF DEATH: **Eliza Higgins**

2. SEX: **Female**

3. RACE: **White**

4. MARRIAGE STATUS: **Single**

5. OCCUPATION: **Dentist**

6. SOCIAL SECURITY NUMBER: **unknown**

7. CAUSE OF DEATH: **Bronchopneumonia**

8. RESIDENCE: **Rockford, Illinois**

9. DATE OF BIRTH: **3-18-89**

10. DATE OF DEATH: **February 16, 1959**

11. ADDRESS: **Rockford, Illinois**

12. RELATIONSHIP TO DECEASED: **Higgins**

13. MOTHER'S FULL MARRIAGE NAME: **unknown**

14. ADDRESS: **Eliza Higgins**

15. RELATIONSHIP TO DECEASED: **Eliza State Hospital Hospital Records**

PART I - DEATH WAS CAUSED BY (state only one cause per line for IAL, IBL, and ICI)

IMMEDIATE CAUSE (IA) **Bronchopneumonia**

CONDITIONS, IF ANY, WHICH GAVE RISE TO THE ABOVE IMMEDIATE CAUSE (AI) (state the UNDERLYING CAUSE FIRST)

PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I

19. AUTOPSY? YES NO

20. DESCRIBE CIRCUMSTANCES OF INJURY, IF ANY, WHOSE NATURE IS MENTIONED IN PART I OR PART II ABOVE

21. I hereby certify that I attended the deceased from **April 1, 1958** to **February 11, 1959** that I last saw the deceased alive on **February 11, 1959** and death occurred at **1:55 P.M.** from the cause and on the date stated above.

DATE: **2/16/59** SIGNED: **Jose Visarri M.D.** ADDRESS: **Eliza State Hospital SR 2-1040** PHONE: _____

22. DISPOSITION: **BURIAL REMOVAL CRIMATION DATE: 2-18-59**

CEMETERY: **Calvary**

LOCATION: **Rockford Illinois**

23. FIRM NAME: **John F. Long**

ADDRESS: **North Ct. & Park Ave. Rockford, Illinois**

SIGNATURE: **John F. Long** (Deputy) **Myrtle E. Spiegler** (LOCAL REGISTRAR)

24. Received for filing on: **February 16, 1959** (Signed) **John P. Smith** (Deputy)

FILE ON REVERSE SIDE OF THIS FORM - DO NOT PRINT IN THESE SPACES