

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Livingston
Township Crossfield
or
Village Chula
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 509
Primary Registration District No. 4309

File No. _____
Registered No. 9241
6

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Carl Raymond Gibson

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH February 26, 1914
(Month) (Day) (Year)

AGE 1 yrs. 6 mos. 6 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Chula mo

NAME OF FATHER J. M. Gibson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri

MAIDEN NAME OF MOTHER Mandy Reever

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Gibson
(ADDRESS) Chula mo

Filed March 10th 1915 Thos. G. Hooker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 5, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 27, 1915, to March 5, 1915, that I last saw him alive on March 4, 1915, and that death occurred, on the date stated above, at 12:30 (a.m. or p.m.)
The CAUSE OF DEATH* was as follows:

Meningitis
10th 179^A (Duration) ___ yrs. ___ mos. 13 ds.
Contributory Catarrhal Pneumonia
(SECONDARY) (Duration) ___ yrs. ___ mos. 6 ds.

(Signed) L. P. Curly M. D.
March 5, 1915 (Address) Chula Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 1 yrs. ___ mos. 6 ds. In the State 1 yrs. ___ mos. 6 ds.
Where was disease contracted if not at place of death? at Place Death
Former or usual residence none

PLACE OF BURIAL OR REMOVAL May Cemetery DATE OF BURIAL March 6th 1915
UNDERTAKER W. B. ... ADDRESS Chula mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Livingston Registration District No. 509 File No. _____
 or Township Chula Primary Registration District No. 4309 Registered No. C
 or Village _____ St.: _____ Ward _____
 or City _____ (NO. _____ St.: _____ Ward _____)

FULL NAME Carl Raymon Gibson

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF FACE W. SINGLE MARRIED WIDOWED OR DIVORCED S.
 (Write the word)

DATE OF BIRTH _____ 191____
 (Month) (Day) (Year)

AGE _____
 IF LESS than 1 day, _____ hrs. or _____ min.
 _____ yrs. _____ mos.

OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 4-10 1915 Shot & Graham
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/5/1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw him _____, 191____,

and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* was as follows:

meningitis following
bronchial pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Catharrhal Pneumonia
 (SECONDARY)

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed) L. P. Corlybe M. D.

3-5 1915 (Address) Chula Mo

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCE)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

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Association]

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