WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County: Callaway

Township: St Aubert

or Village: X

or City: X (NO. ____, ____ St.; ____ Ward)

Registration District No. 105

Primary Registration District No. 513-4

File No. 16346

Registered No. 13

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

FULL NAME John Gibson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Caucasian

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: Don't Know (Month) ____ (Day) 1 (Year)

AGE: 61 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Janitor at Infirmary
(b) General nature of industry, business, or establishment in which employed (or employer): of Callaway Co.

BIRTHPLACE (City or town, State or foreign country): Don't Know

PARENTS
NAME OF FATHER: Don't Know
BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know
MAIDEN NAME OF MOTHER: Don't Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. H. Wilkerson

(ADDRESS) Fulton Mo

Filed June 4 1918 W. H. Williamson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 18 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from March, 1918, to May 18, 1918, that I last saw him alive on May 16, 1918, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

1/2 hour (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Arterio sclerosis (Duration) 6 yrs. ____ mos. ____ ds.

(Signed) C. H. Christian M. D.

5/18/ 1918 (Address) Fulton 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 ____ 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: County Infirmary

DATE OF BURIAL: 5/18/ 1918

UNDERTAKER: G. H. Wilkerson

ADDRESS: Fulton Mo

PLACE OF DEATH

County

Township
or
Village
or
City (NO. , St.; Ward)

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

Registration District No.

Primary Registration District No.

File No.

Registered No.

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

DATE OF BIRTH
(Month) (Day) (Year)

AGE
yrs. mos. 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)

PARENTS

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 , 191 ,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
(Month) (Day) , 191 (Year)

I HEREBY CERTIFY, that I attended deceased from , 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)
(Duration) yrs. mos. ds.

(Signed) M. D.

, 191 (Address)

*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 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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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