LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

ty Jasper

ship ~~Mineral~~

Registration District No. 412 / 4244 File No. 31911

Primary Registration District No. 412 Registered No. 5

ge Neck (NO. ..... St.: ..... Ward)

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

FULL NAME James Gibson

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
ale	Amer	Married

E OF BIRTH Dec. 5, 1844 (Month) (Day) (Year)

75 yrs. 10 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

UPATION rade, profession, or cular kind of work Lehering Papers

eneral nature of industry ess, or establishment in employed (or employer)

HPLACE r town, foreign country) Ohio

10 NAME OF FATHER James Gibson

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

12 MAIDEN NAME OF MOTHER Margrete French

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

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

ormant) Chas Keefe

(Address) Neck Mo

d Oct 9, 1920 W. J. Hogan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 8 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from X, 191..., to X, 191...

that I last saw h..... alive on 10-5, 1920

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

The CAUSE OF DEATH* was as follows:

Appoplexy

64

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Short M. D.

10-8, 1920 (Address) Purcell Mo

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL Purcell Cem

DATE OF BURIAL Oct 9, 1920

20 UNDERTAKER Knell und Co

ADDRESS Carthage

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occu
hospital or in
give its NAME
of street and n

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 191

17 I HEREBY CERTIFY, that I attended decease
....., 191....., to ....., 19
that I last saw h.....alive on ....., 19
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) .....yrs. .....mos. .....

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....

(Signed) .....

....., 191..... (Address) .....

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

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19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....,
20 UNDERTAKER	**ADDRESS**