

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

Do not use this space.

9808

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **909²**) **W. Jefferson** St. (Ward)

File No.
Registered No. **2369**

2. FULL NAME

Rosa Lee Gibbs
(a) Residence, No. **909² W. Jefferson** St., **21** Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** | 4. COLOR OR RACE **Colored** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar. 14, 1906**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
20		11	27	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

PARENTS

10. NAME OF FATHER **Abraham Gibbs**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

12. MAIDEN NAME OF MOTHER **Estella Keith**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

14. INFORMANT **Mr. Abraham Gibbs**
(Address) **909² W. Jefferson**

15. FILED **Mar 16 1927**
REGISTRAR **Max Starckoff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar. 7, 1927**
17.

I HEREBY CERTIFY, That I attended deceased from **Feb. 2, 1927**, to **Mar. 7, 1927** that I last saw him alive on **March 7, 1927**, and that death occurred, on the date stated above, at **8:15 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(Zylogian)
Acute Myocarditis due to
to pericarditis inflammation
perhaps Tubercular
CONTRIBUTORY **Ascaris a General from**
perhaps Tubercular

18. WHERE WAS DISEASE CONTRACTED

IF AT PLACE OF DEATH.....

DID OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Typ. signs**

(Signed) **Ernest Jones, M.D.**
March 8, 1927 (Address) **2406 Lawton**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood** DATE OF BURIAL **Mar. 10 1927**

20. UNDERTAKER **J.H. Harrison** ADDRESS **2406 Lawton**

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.

THIS IS A PERMANENT RECORD

