

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

Do not use this space.

10008

1. PLACE OF DEATH

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

File No.
 Registered No. **2534**

2. FULL NAME

David Gibson
 (a) Residence. No. **2652 Morgan** St., **21** Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Col** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widow**
 5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Widow**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 5, 1883**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **41 11 8.**
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Invalid 114**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Miss** (STATE OR COUNTRY)
 10. NAME OF FATHER **Henry Gibson**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Miss** (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Patsy White** (Address) **114/29**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Miss** (STATE OR COUNTRY)

14. INFORMANT **Fannie Busby** (Address) **2652 Morgan**
 15. FILED **Mar 6 1929** **Mar 6 Starks** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 12, 1927**
 17. I HEREBY CERTIFY That I attended deceased from **3/12/27** to **3/12/27**, 19**27**, that I last saw **him** alive on **3/12/27** and that death occurred, on the date stated above, at **11 P.**
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
 (duration) yrs. mos. **10** da.
 CONTRIBUTORY (SECONDARY) **La Grippe** (duration) yrs. mos. **4** da.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 19. DID AN OPERATION PRECEDE DEATH..... DATE of

20. WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **J. Johnson** M. D.
 (Address) **2603 Morgan**
 *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 **Washington Park** DATE OF BURIAL **Mar 16 1929**
 20. UNDERTAKER **L. B. Beal** ADDRESS **2724 Genesee**

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.

MARKED RESERVED FOR DRUGS

V. S. 46. 2.

