

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

Do not use this space.

6890

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis (No. 5842) Theodore

File No.....  
Registered No. 1853  
St. Ward)

**2. FULL NAME**

Rosemuth Orlando Gibson  
(a) Residence No. 5842 Theodore St., 6 Ward.  
(Usual place of abode)  
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 Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/17-28

7. AGE YEARS MONTHS DAYS H LESS than 1 day, hrs. or min.  
2

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Hennrich B. Gibson

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

12. MAIDEN NAME OF MOTHER Helen Ryan

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

14. INFORMANT Hennrich B. Gibson  
(Address) 5842<sup>nd</sup> Theodore

15. FILED 558 20 19 28 Maule Starckoff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-19-1928

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17<sup>th</sup>, 1928 to Feb. 19<sup>th</sup>, 1928 that I last saw him alive on Feb. 18<sup>th</sup>, 1928, and that death occurred, on the date stated above, at 5:00 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Premature Birth  
159  
(duration) yrs. mos. da. 2  
CONTRIBUTORY (SECONDARY) 161A  
(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY.....

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) Orlando G. Gibson, M. D.

2/19, 1928 (Address) St Louis Mo

\*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**

Calvary Cemetery

**DATE OF BURIAL**

Feb 20 19 28

**20. UNDERTAKER**

Cullinane Bros

**ADDRESS**

1710 N. Grand

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.

