

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

Do not use this space.

43652

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **145**  
St. .... Ward)

**2. FULL NAME** *Gillian Gibson*

(a) Residence. No. **2868** *Missouri St.*, **11** Ward.  
(Usual place of abode) *city*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. *11* mos. *11* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

*Female* | *Col* | *Single*

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

*Single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-7-1906*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *22* | *7* | *22* | *11*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Lumbrist*

(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) *Tenn*

10. NAME OF FATHER *Henry Lolor*

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

12. MAIDEN NAME OF MOTHER *Marion Chopton*

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

14. INFORMANT *Clay Harris*

(Address) *3868 Kingsway*

15. FILED *1 1920* *Max C Standley* REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec-29-1928*

17. I HEREBY CERTIFY, That I attended deceased from *12-29-1928* to *12-29-1928* that I last saw h. e. r. alive on *12-29-1928*, and that death occurred, on the date stated above, at *5:30 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Apical abscess of tooth B (1st molar)*

CONTRIBUTORY *Faemia* (SECONDARY) *unknown* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF BIRTH?) *unknown*

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *12-27-28* WAS THERE AN ANESTHETIC? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Autopsy*  
(Signed) *E. Kenneth Lewis*, M. D.  
, 19 (Address) *600 So. Kingsway*

\*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 *Jackson Tenn* DATE OF BURIAL *1-4-29*

UNDERTAKER *Pinkie Toney* ADDRESS *8129 S. Cass*

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.

