

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

Do not use this space.

20230

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* (No. *City Hospital #2*)..... St. Ward)

File No.....
 Registered No. **5911**
 St. Ward)

2. FULL NAME

Bemmas Gibson
 (a) Residence, No. *1228 N. 14th* St., *25* Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred *2* yrs. mes. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar. 26, 1912*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>17</i>	<i>2</i>	<i>0</i>	

8. OCCUPATION OF DECEASED

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

Nil

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

10. NAME OF FATHER

Levy Gibson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

12. MAIDEN NAME OF MOTHER

Natie Lipscomb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

14.

INFORMANT (Address)

Angie Hill Rogers City Hospital #2

15.

FILED

MAY 29 1929 May 27 1929

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-26-1929*

17. I HEREBY CERTIFY, That I attended deceased from *5-26-1929* to *5-26-1929*, 19*29* that I last saw h. *22* alive on *5-26-1929*, 19*29*, and that death occurred, on the date stated above, at *11:45 p* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

6 hrs. myocarditis
93c (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

700 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *clinical*

(Signed) *T. J. Cunningham*, M. D.

, 19 *29* (Address) *2945 Sawton*

*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

DATE OF BURIAL

Washington Park 5-29-1929

20. UNDERTAKER

ADDRESS

Wade Finney 4202

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.

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