21445

Do not use this space.

21445

2580

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

1. PLACE OF DEATH
County Jackson — Registration District No. ..... — File No. .....
Township Raw — Primary Registration District No. ..... — Registered No. .....
City Kansas City (No. 3567 White St. ..... Ward)

2. FULL NAME Florence Gibson
(a) Residence. No. 3567 White St., 14 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 30, 1889

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
40	0	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(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): Alabama

PARENTS
10. NAME OF FATHER: Ben Herring
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ala
12. MAIDEN NAME OF MOTHER: Emma Ank
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ala

14. INFORMANT: Roy Gibson
(Address) 3567 White

15. FILED 6/8, 1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/6 1929.

17. I HEREBY CERTIFY, That I attended deceased from 6 6, 1929 to 6-6, 1929 that I last saw her alive on 6-6, 1929 and that death occurred, on the date stated above, at 3:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral apoplexy
82 A
57 A
156 A (duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (SECONDARY) ankylosis of mural joints Rheumatoid arthritis (duration) 2 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) L V Nuller, M. D.
6/6, 1929 (Address) 1426 E 18

*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: Blue Ridge Lawn — DATE OF BURIAL: 6/8 1929

20. UNDERTAKER: Watkins Bros — ADDRESS: 1729 Lydia

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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L. V. Miller.