

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

Do not use this space.

18521929
1929
198
39

1. PLACE OF DEATH

County Lafayette
Township Clay
City Ocala Mo. (No.)

Registration District No. 464
Primary Registration District No. 4277

File No.
Registered No. 39
St. Ward)

2. FULL NAME James Ora Gibson

(a) Residence No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>72</u>	<u>0</u>	<u>27</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 928
(b) General nature of industry, business, or establishment in which employed (or employer) 956
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jackson Co. Louisiana Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Mrs E. Gibson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lexington Kentucky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Bertie McConuty

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lexington Ky.
(STATE OR COUNTRY)

14. INFORMANT Iida Gibson
(Address) Ocala Mo.

15. FILE NO. Aug 10 29 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1929

17. I HEREBY CERTIFY That I attended deceased from April 30, 1929 to June 23, 1929 that I last saw him alive on June 23, 1929 and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Endocarditis with failing compensatory general anasarca

CONTRIBUTORY (SECONDARY) General Anasarca
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED ALL
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) [Signature] (Address) Ocala 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 Ocala Crm DATE OF BURIAL 6/25 1929

20. UNDERTAKER Shmo & Sons ADDRESS Ocala Mo.

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.

26 1929 528 88 2 262 1 2 2

