

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

Do not use this space.

32398

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. 4111 a Finney) St. .... Ward)

File No. 9496  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(a) Residence No. 4111 a Finney St. Ward 11  
(Usual place of abode)  
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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Gibson

7. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
52 3 29

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Atlanta, Ga.  
(STATE OR COUNTRY)

10. NAME OF FATHER Isaac Gibson

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

12. MAIDEN NAME OF MOTHER Mrs. Gibson

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

14. INFORMANT Sarah Gibson  
(Address) 4111 a Finney

15. FILED SEP 23 1928 REGISTRAR Max C. Stanley

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-10-29 to 9-19-29, 1929, and that I last saw him alive on 9-19-29, 1929, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cancer of stomach

465 (duration) yrs. 4 mos. .... ds.

CONTRIBUTORY (SECONDARY) 440 (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 (Signed) W. B. Bridges, M. D.

, 19 (Address) 917 1/2 N. Sarah St

\*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

Father Gibson Cem. Sept 29 1929

20. UNDERTAKER Manuel Galt Co. ADDRESS Finney

245-2-31

