

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.

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

Do not use this space.

32666

24 1929

1. PLACE OF DEATH

County Saline

Registration District No. 796

Township Marshall

Primary Registration District No. 3038

City Marshall (No. _____)

File No. _____

Registered No. 141

St. _____ Ward _____

2. FULL NAME William L. Gibson

(a) Residence. No. _____ St. _____ 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 22, 1865</u>		
7. AGE YEARS <u>64</u>	MONTHS <u>1</u>	DAYS <u>27</u>
If LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mason Co
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Wife) Mrs Gibson
(Address)

15. FILED 9-22-29 Mrs John H. McQuire
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 15, 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1929 to Sept 16 1929 that I last saw h./a/a alive on Sept 15 1929, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Myocardial Regurgitation
92A
111B

CONTRIBUTORY (SECONDARY) Hypertensive Pneumonia
(duration) _____ yrs. _____ mos. _____ ds.

18. WHEN WAS DISEASE CONTACTED 9/16
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] M. D.
9/16 1929 (Address) Marshall 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 Ridge P. Cemetery DATE OF BURIAL Sept 17 1929

20. UNDERTAKER J. L. Swanson ADDRESS Marshall, Mo.

