

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

Do not use this space.

18438

**1. PLACE OF DEATH**

County Waukegan  
Township Mill Spring  
City Rolla

Registration District No. 895  
Primary Registration District No. 6197

File No. ....  
Registered No. 9  
St. .... Ward)

**2. FULL NAME**

Polly Rohanna Gibbs  
(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 Female 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 Robert Gibbs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 6, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
65 4 8

**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) Housework.  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. C.

10. NAME OF FATHER John Bentel

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

12. MAIDEN NAME OF MOTHER Nancy Gerde

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

14. INFORMANT (Address) Robert Gibbs  
Mill Spring, Mo.

15. FILED 5/14 30 Ray J. Moore REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

17. I HEREBY CERTIFY that I attended deceased from April 7, 1930 to May 14, 1930, that I last saw him alive on May 12, 1930, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
Hypostatic Pneumonia  
196A  
194B

1 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fracture of Hip  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Ray J. Moore M. D.  
5/14 1930 (Address) Mill Spring

\*State the DISEASE CAUSING DEATH, or in death 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  
Mill Spring Mo 5/15 1930

20. UNDERTAKER ADDRESS  
None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

...

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...

...

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Wheeler Registration District No. 895- File No. ....  
 Township Mill Springs Primary Registration District No. 6197 Registered No. 9  
 City ..... St. .... Ward)

2. FULL NAME

Polly Roxanna Gibbs

(a) Residence. No. .... St. .... Ward. .... (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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

5/14 3 Roy J. Owens  
 FILED 1920 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

17. I HEREBY CERTIFY, That I attended deceased from .....

that I last saw h. .... alive on ....., 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Caught the head in pole in  
causing her to fall  
over back of wood.

(duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Fracture of hip  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? 5

(Signed) ..... M. D. , 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18438