

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

Do not use this space.

19628

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township New Primary Registration District No. 1002  
 City Kansas City (No. 554 Cherry St.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 2529  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Allie Gibson

(a) Residence No. 554 Cherry St., \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 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>col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gertrude Gibson</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 21, 1904</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>26</u>	<u>3</u>	<u>2</u>	

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 employed) Common Labourer

(c) Name of employer unbrworn

9. BIRTHPLACE (CITY OR TOWN) New Franklin  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER James Gibson

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

12. MAIDEN NAME OF MOTHER Zephyra Graves

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

14. INFORMANT Zephyra Graves  
 (Address) 1515 4 Cherry St.

15. FILED 6/24/30 M. M. Grove  
 REGISTRAR AMR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-23-30

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary tuberculosis  
23P (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31  
 (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS?  
signed for autopsy \_\_\_\_\_, M. D.  
 (Address) 1200 E. 12th

\*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 Westlawn DATE OF BURIAL June 28 1930

20. UNDERTAKER Robins Bros ADDRESS 2000 E. 12

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.

