

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1008**
 City **St. Louis** No. **City Hospital # 2** St. Ward) **17**

19995
 File No.
 Registered No. **6026**

2. FULL NAME

(a) Residence. No. **4435 Evans** St., **11** Ward. **St. Louis, Mo.**
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE Caucasian	5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 1907		
7. AGE YEARS about 35	MONTHS —	DAYS —
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) (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER John Gibson
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER Mollie Gibson
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT **Hassie Lee Bentz**
 (Address) **3316 Stanton Ave**

15. FILED **20** 19**01**
May 2 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

20. **20** MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-32-1931**

17. **No Physician in Attendance**
 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:
Shock & injuries
Crushed legs & chest run over by Railroad in St. Louis Mo. No Automobile
Accident

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

18. WHERE WAS DISEASE CONTACTED? **2017**
 IF NOT AT PLACE OF DEATH **2017**

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **J. W. Ferrer** M.D.
 (Address) **Dep. Coroner**

*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 **Washington Park** DATE OF BURIAL **5-30-1931**

20. UNDERTAKER **J. S. Wade** ADDRESS **420 W. Finney Ave.**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

