

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

Do not use this space. *W*

1. PLACE OF DEATH

County Jackson Registration District No. 390
Township Haw Primary Registration District No. 1002
City McC. Mo. (No. 3419) Street Frost

20342

File No. _____
Registered No. 2508
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3419 Frost 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

SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 4 1873</u>		
7. AGE YEARS <u>41</u>	MONTHS <u>1</u>	DAYS <u>2</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>None</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Maryland</u>		
13. NAME <u>Roscoe Gibson</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>		
15. MAIDEN NAME <u>Mary Robinson</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>West Virginia</u>		
17. INFORMANT <u>B. V. Gibson</u> (ADDRESS) <u>4416 Marshall St. C. Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Golden Cemetery</u> DATE <u>May 8 1934</u>		
19. UNDERTAKER <u>W. J. Goodman</u> (ADDRESS) <u>Golden Mo.</u>		
20. FILED <u>June 6, 1934</u> <u>M. M. Crowe</u> <u>Cash Registrar.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 6 1934

22. I HEREBY CERTIFY That I attended deceased from Feb 6 1934 to June 6 1934
I last saw him alive on June 19 1934 Death is said to have occurred on the date stated above, at 6:45 P.M.
The principal cause of death and related causes of importance were as follows:
Pre-retal abscess Date of onset _____
Sepsis
Other contributory causes of importance:
Sepsis

Name of operation None Date of _____
What test confirmed diagnosis? None Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify _____
(Signed) J. W. McWhorter M. D.
(Address) Kansas City

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.

JUL 17 1934

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

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Dr. J. Smith

Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Carl Gibson
Who died at 3419 Tower on June 6 - 1934
Residence: No. 3419 Tower St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth Sept 4 - 1923 Age: Years 41 Months 1 Days 2

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retail Store
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year Several years ago

Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____

Principal cause of death: As seen seemed to emanate from lower part of spinal bone - drained freely - unknown cause of the degenerative condition
Other contributory causes of importance: duplex meningitis (not tuberculous)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____
Name of physician J. W. Aalburtson - R. E. Ma
Address of physician Westside Bank Bldg Date filed 6/16/34
Signature of Registrar: M. M. Brown

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours
Reg. Dist. No. _____
Primary Reg. Dist. No. _____
He was of an inferior complex and always unable to walk as he should - form of paralysis existed - He did not work for many years
E. T. McGaugh
Special Agent, State Registrar

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