

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.

MAR 25 1935

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

Do not use this space.

5064

1. PLACE OF DEATH

County *Greene*
Township *Franklin*
City *Springfield*

Registration District No. *322*
Primary Registration District No. *5446*

File No. _____
Registered No. *44*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <i>Grace Gibony</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Dec 6 - 1878</i>		
7. AGE	YEARS <i>57</i>	MONTHS <i>2</i>
	DAYS <i>14</i>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Farmer</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>On farm</i>	
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 20* 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *1931*, 19____, to *1935*, 19____

I last saw him alive on *Dec 1934* Death is said to have occurred on the date stated above, at *5:00 A.M.*

The principal cause of death and related causes of importance were as follows:

Vascular hypertension Date of onset *1928*

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ 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? _____ If so, specify _____

(Signed) *Robert Glyn* M. D.

(Address) *Springfield Mo*

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo.</i>
	13. NAME <i>John T. Gibony</i>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo.</i>
	15. MAIDEN NAME <i>Sarah A. Boone</i>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo.</i>
	17. INFORMANT (ADDRESS) <i>Carl J. Gibony Mo.</i>
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>St. Mary's Cemetery</i> DATE <i>Feb. 21 1935</i>	
19. UNDERTAKER (ADDRESS) <i>J. H. Klugger St. Springfield Mo.</i>	
20. FILED <i>Feb 22</i> 19 <i>35</i> <i>William Barnes</i> Registrar.	

