

JAN 15 1938

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

Do not use this space.

1. PLACE OF DEATH

City *St. Louis*
Township *Platt*
City *St. Louis* (No. *157*)

Registration District No. *157*
Primary Registration District No. *5219*

File No. *44514*
Registered No. *14*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *Virginia St. Gibson* St. *Rose* 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) *Single*
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-22-37*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *0-0-0*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *None*
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) *Andrew Co. Mo.*

13. NAME *Clayton Gibson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

15. MAIDEN NAME *Bulah-Wall*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Clayton Gibson, 157 Virginia St. St. Louis, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *St. Charles 12-23-37*

19. UNDERTAKER (ADDRESS) *St. Charles*

20. FILED *12/28 1937 Mrs. E. C. Jefferies Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-22-1937*

22. I HEREBY CERTIFY, That I attended deceased from *12-22 1937* to *12-22 1937*
I last saw her alive on *12-22 1937*. Death is said to have occurred on the date stated above, at *4:30 p.m.*

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

Monstrous partial development of occipital and parietal bones

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) *E. C. Jefferies*, M. D.
(Address) *157 Virginia St., Mo.*

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.

