

APR 13 1939

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

10880  
Do not use this space.

*En Robert Williams*

1. PLACE OF DEATH **GREENE** 2  
 (a) County **GREENE** Registration District No. **318**  
 (b) Township **N. (unintelligible)** Primary Registration District No. **5439**  
 (c) City **SPRINGFIELD** (d) Street No. **Route 2** Registered No. **239**  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.  
 125 **William J. Gibson**  
 2. PRINT FULL NAME  
 (a) Residence, No. **Route 2, Springfield** St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) **Widower**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF **Hattie (deh 1906)**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 5, 1858**  
 7. AGE YEARS **80** MONTHS **11** DAYS **14** If LESS than 1 day, hrs. or min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Ret. Farmer**  
 9. Industry or business in which work was done, as saw mill, bank, etc. **On Farm**  
 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) **March 19, 1939**  
 22. I HEREBY CERTIFY, That I attended deceased from **Aug 10, 1938**, to **March 19, 1939**  
 I last saw him alive on **March 19, 1939**. Death is said to have occurred on the date stated above, at **4 P.** m.  
 The principal cause of death and related causes of importance were as follows:

**Chronic Valvular Heart Disease**  
**Had been in poor health for 2 or 3 years.**  
 Other contributory causes of importance:  
**Rectal Disease etc**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Palmetto, Mo.**  
 FATHER 13. NAME **WUK**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **WUK**  
 MOTHER 15. MAIDEN NAME **WUK**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **WUK**

Name of operation **None** Date of.....  
 What test confirmed diagnosis? **r** Was there an autopsy?.....

17. INFORMANT (ADDRESS) **Mrs. A. E. Webb**  
**Route 2, City**  
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Danforth** DATE **May 21, 1939**  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Alma Schreyer**  
**Springfield Mo**  
 20. FILED **Mar 21, 1939** **Chas. W. George** Local Registrar

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 **no**  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased? **No**  
 If so, specify.....  
 (Signed) **Robert Williams**, M. D.  
 (Address) **Springfield Mo**

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.

WRITE PRINTED WITH CARE

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_  
\_\_\_\_\_, or by \_\_\_\_\_  
Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**