DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35475

Registration District No. 73 | Primary Registration District No. 3006 | Registrar's No. 209

**1. PLACE OF DEATH:**

(a) County: Boone

(b) City or town: Columbia

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 802 Hillcrest Ave.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: One year

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo (b) County: Boone

(c) City or town: Columbia (If outside city or town limits, write "RURAL")

(d) Street No.: 802 Hillcrest ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: JOHN BOSS GIBSON

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of ~~husband or~~ wife: Arzetta Gibson

6. (c) Age of ~~husband or~~ wife if alive: 45 years

7. Birth date of deceased: April (Month) 28 (Day) 1865 (Year)

8. AGE: Years: 74 | Months: 5 | Days: 22 | If less than one day: ____ hr. ____ min.

9. Birthplace: Salem (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: ____

FATHER
12. Name: John Wilson Gibson
13. Birthplace: Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Frances Buckworth
15. Birthplace: Benton Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs. Arzetta Gibson
(b) Address: 802 Hillcrest Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-22-39 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Salem, Mo.

18. (a) Signature of funeral director: Leslie Hopson
(b) Address: Salem, Mo.

19. (a) 10/21/39 (Date received local registrar) (b) Allie Selby (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 10 day 20 year 1939 hour 5-30 minute P. M.

21. I hereby certify that I attended the deceased from 10-18, 1939, to 10-20, 1939, that I last saw him alive on 10-20, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days

Due to: Do not know.

Due to: ____

Other conditions (Include pregnancy within 3 months of death): None

Major findings: Of operations: None

Of autopsy: No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): No
(b) Date of occurrence: ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____
While at work? ____ (Specify type of place) (e) Means of injury: ____

23. Signature: W. D. Dysart (M. D. or other)
Address: Columbia Mo. Date signed: 10-21-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39

## 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 [illegible], Registered Apprentice No. 161, working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 3893

P. O. Address Columbia, mo

**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.**