

MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Hardin
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Wheatley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life years, months or days

3. (a) PRINT FULL NAME Dora G. T. H. S. 420

3. (b) If veteran, name war Dora Giles No. no
3. (c) Social Security No. no

4. Sex Female 5. Color or race Black
6. (a) Single, widowed, married, divorced Marr.

6. (b) Name of husband or wife Jimmie Ray Gibb 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Dec. 15, 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>4</u>	<u>19</u>	hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Alford, Reeves

13. Birthplace Hardin Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Randall

15. Birthplace Marion Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ray Miller

(b) Address Hardin Mo.

17. (a) Hardin Cemetery (b) Date thereof May 1, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hardin Cemetery

18. (a) Signature of funeral director R. H. Rogers

(b) Address Hardin Mo.

19. (a) April 29, 1940 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Hardin
(c) City or town Wheatley, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 29 day April
year 1940 hour 7 minute _____ M.

21. I hereby certify that I attended the deceased from 4-5-, 1940, to 4-29-, 1940

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death ruptured fibroid uterus
Due to fibroid uterus
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Fibroid uterus et. ruptured tube
Of operations _____
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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 R. H. Rogers (M. D. or other) _____
Address 2700 E. 18th Date signed 4-29-40

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.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 RR Rogers

Licensed Embalmer No. 9576

P. O. Address Hardin mo

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

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

B
40,
2659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14097-40

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1809-

1. PLACE OF DEATH:

(a) County Jackson, mo
(b) City or town St. Louis
(c) Name of hospital or institution: Wheatley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. Harden (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Dora Giles

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Cool 6. (a) Single, widowed, divorced, Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 29 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Captured Gallbladder tube Fibroid uterus
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

