

97 MAY 15 1940

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

15902
Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 252
 (b) Township Pine Primary Registration District No. 5-993
 (c) City or _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

2. PRINT FULL NAME Lisbon B. Gibson,

(a) Residence, No. Pine St. 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) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Samantha Gibson (deceased)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 15, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 I 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 1940
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford Co. Mo.

FATHER 13. NAME Wm. Oakly Gibson,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER 15. MAIDEN NAME Mary Frances Glore

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Francis Co. Mo.

17. INFORMANT Wm. T. Foster
 (ADDRESS) Handy, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pine Cem. DATE 4-25- 19 40

19. FUNERAL DIRECTOR (NAME) John Pigg,
 (ADDRESS) Bennett, Mo.

20. FILED 4-26 19 40 J. H. Sprague Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 24th, 1940

22. I HEREBY CERTIFY, That I attended deceased from This patient was moribund when I last saw first seen by me - 19 19
 to have occurred on the date stated above, at 3.30 P.M.
 The principal cause of death and related causes of importance were as follows:

Apoplexia, (10 A.M. 4-24-40)
 Date of onset
 Other contributory causes of importance: Hypertension,

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) J. H. Cannon, M. D.
 (Address) Van Buren, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS who CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.
Health Officer No. 5,
District File Number 540 523
Date Filed 5/18/40

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.