

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. 28440

Registration District No. \_\_\_\_\_ Primary Registration District No. 2001-528 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Dunklin Mo.  
 (b) City or town Bucoda  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 (Specify whether  
 In this community Yes  
 years, months or days

3. (a) PRINTED FULL NAME A. J. GIBSON 178  
 8. (b) If veteran, name war / 8. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 19 1918  
 (Month) (Day) (Year)

8. AGE: Years 22 1/2 Months 7 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name A. J. Gibson  
 { 13. Birthplace Henderson Co. Tenn  
 { (City, town, or county) (State or foreign country)  
 { 14. Maiden name Nevers Neumann  
 { 15. Birthplace Henderson Co. Tenn  
 { (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. J. Gibson  
 (b) Address Bucoda Mo.

17. (a) 9/4-1940 (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M<sup>e</sup> Green Cemetery

18. (a) Signature of funeral director H. H. Howard

(b) Address Cardwell Mo.

19. (a) Sept 6 1940 (b) A. J. Gibson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Dunklin  
 (c) City or town Senack - Rural  
 (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 Sept day 3d  
 year 1940 hour 12 minute 35 M.

21. I hereby certify that I attended the deceased from August 31  
 \_\_\_\_\_, 1940, to Sept 3, 1940;  
 that I last saw him alive on Sept 3, \_\_\_\_\_, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure + ascites

Due to Heart decompensation

Due to \_\_\_\_\_

Other conditions Tuberculosis of bones  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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) \_\_\_\_\_

(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. C. Glasgow (M. D. or other) \_\_\_\_\_  
 Address Cardwell Mo Date signed 9-3-40

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

RECEIVED

District Health Officer No. 2

District File Number 940-1429

Date Filed 9/7/40

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28440**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **290**

Primary Registration District No. **2408**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Salem, T.C.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME W. C. Gibson

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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 <u>22</u>	Months <u>7</u>	Days <u>22</u>	If less than one day _____ hr. _____ min.
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9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) Sept. 6, 1940 (b) A. S. McDaniel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin

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

(d) Street No. \_\_\_\_\_ (If rural, give location) Rural - Bucoda

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

20. DATE OF DEATH: Month Sept day 9  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_

SUPPLEMENTAL CERTIFICATION

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text, possibly a signature or name, located in the middle right area.

Handwritten text, possibly a signature or name, located at the bottom right of the page.