

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.

OCT 23 1940

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

32942
Do not use this space.

1. PLACE OF DEATH *2 0*
 (a) County *Reynolds* Registration District No. *749*
 (b) Township *Lester* Primary Registration District No. *6984*
 (c) City _____ (d) Street No. _____ Registered No. _____
 (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.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME *Philip Vernon Gibbons*
 (a) Residence, No. _____ 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 *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug. 27 1931*

7. AGE	YEARS	MONTHS	DAYS	if LESS than 1 day, hrs. or min.
<i>8</i>	<i>11</i>	<i>24</i>		

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) *Lester, Mo*

FATHER

13. NAME *Jos Gibbons*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Rismack, Mo.*

MOTHER

15. MAIDEN NAME *Mable Pickley*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hogan, Mo.*

17. INFORMANT (ADDRESS) *Jos Gibbons, Lester, Mo.*

18. BURIAL, CREMATION OR REMOVAL PLACE *Four Oaks Cemetery* DATE *8/20/1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Norman White, 4200 Front St, Lester, Mo.*

20. FILED *8/20/1940* *E. M. Fitzpatrick, Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 18 1940*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 11, 1940* to *Aug. 18, 1940*
 I last saw him alive on *Aug. 9, 1940*. Death is said to have occurred on the date stated above, at *7:30 p.m.*
 The principal cause of death and related causes of importance were as follows:
arteriosclerotic nephritis Date of onset _____

Other contributory causes of importance:
Pulmonary obstruction

Name of operation *none* Date of _____
 What test confirmed diagnosis *Clinical* Was there an autopsy? *no*

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? *no*
 If so, specify _____ (Signed) *C. M. Whitbeck* M. D.
 (Address) *Lester, Mo.*

RECEIVED
District Health Officer No. 5,
District File Number 940967
Date Filed _____

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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. **32942**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **749**

Primary Registration District No. **5984**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Reynolds**
(b) City or town **Waterville, Mo.**
(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
years, months or days)

3. (a) **PRINT FULL NAME** **Philip Vernon Gibbons**
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 year

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

8. AGE: Years **8** Months **11** Days **24** If less than one day hr. min.

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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.

20. DATE OF DEATH Month **Aug** day **18** year **1970** 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 **Interstitial Nephritis**
Chr.
Due to
Due to **131**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Pulmonary Opisthorchiasis**
Chronic
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) (Cause of injury)

23. Signature **B. M. Fitzpatrick** M. D. or other)

Address **Waterville Mo** Date signed **11/25/70**

SUPPLEMENTAL

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

