

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **37953**
Registrar's No. **4551**Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **4551**

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10-23-40-10-28
(Specify whether
 In this community 64 years
years, months or days)

3. (a) PRINT FULL NAME Jess Gibson3. (b) If veteran, name war No 3. (c) Social Security No. NO4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Unknown6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 16 years7. Birth date of deceased (Month) 5 (Day) 16 (Year) 18628. AGE: Years 78 Months 5 Days 6 10 10 If less than one day hr. min.9. Birthplace Mo. (City, town, or county) (State or foreign country)10. Usual occupation none

11. Industry or business

12. Name Unknown13. Birthplace Unknown (City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown (City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address Gen. Hosp. #217. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-29-1940 (Month) (Day) (Year)(c) Place: burial or cremation K.C. Western Dental Col.18. (a) Signature of funeral director J. M. Carr(b) Address 1513 T. Road19. (a) 11-29-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 507 McGee
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 26
year 40 hour 2 minute 15 A.M.21. I hereby certify that I attended the deceased from 10-23- 1940 to 10-26- 1940;that I last saw him alive on 10-26- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Terminal Pneumonia
(rather broncho or lobar)Due to ArteriosclerosisDue to 47Other 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 J. M. Carr (M. D. or other)Address Gen. Hosp. #2 Date signed 11-29-40

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. 3388

P. O. Address K. C. 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.