

Registration District No. 316 Primary Registration District No. 2001

7
3
6

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

1. PLACE OF DEATH:
County GREENE Springfield
(b) City or town _____
(c) Name of hospital or institution 2027 N. Jefferson
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Greene
(c) City or town Springfield
(d) Street No. 2027 N. Jefferson
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME PATSY LARUE GIBSON

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife (Inf) None 6. (c) Age of husband or wife if alive 9 years

7. Birth date of deceased (Month) Nov. (Day) 9 (Year) 1939

8. AGE: Years 1 Months 0 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business Lat. Home

12. Name M. Floyd Gibson

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

14. Maiden name M. Sarah H. Taylor

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

16. (a) Informant M. Floyd Gibson (b) Address Springfield Mo

17. (a) Funeral (b) Date thereof 11-24-40 (c) Place: burial or cremation My Comfort Cem.

18. (a) Signature of funeral director J. H. Klingner (b) Address Springfield Mo.

19. (a) 11-24-40 (b) W. E. Handley md. (c) _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 21 year 1940 hour 12 minute 35 P. M.
21. I hereby certify that I attended the deceased from Nov 20 to Nov 21, 1940; that I last saw he alive on Nov 21, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia primary cause Duration 10 days

Due to _____
Due to _____
Other conditions 107 W
(Includes pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
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? Yes
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. M. White (M. D. or other) _____
Address Springfield Date signed 11/22/40

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

William Jay Thoda

Licensed Embalmer No.

4071

P. O. Address

Springfield

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, fact should be so stated above.

+