

FILED FEB 17 1941

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

2229  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Clark Registration District No. 189  
 (b) Township Clay Primary Registration District No. 3275  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (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. mo. da. (f) How long in U. S., if of foreign birth? yrs. mo. da.

2. PRINT FULL NAME Dorah May Gibson  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William R. Gibson  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 2 1874  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 66 10 25  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co. Missouri  
 FATHER  
 13. NAME George Riney  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
 MOTHER  
 15. MAIDEN NAME Mary Prohler  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co. Missouri  
 17. INFORMANT (ADDRESS) Wm R. Gibson Canton, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Clinton, Mo. DATE Jan 29 1941  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ed A. Backley Canton, Mo.  
 20. FILED Feb 1 1941 Dr. F. S. Rebo Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 1941  
 22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 7:15 a. m.  
 The principal cause of death and related causes of importance were as follows:  
Died suddenly while preparing breakfast.  
no disease  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: ADD  
 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) L. M. Correll M.D.  
113 (Address) Clinton, Mo.

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.

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RECEIVED

District Health Officer No. 10

District File Number 2-41-302

Date Filed FEB 14 1941

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 Earl H. Barkley

Licensed Embalmer No. 2615

P. O. Address Centon 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2229

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 189

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH

(a) County Clare  
(b) City or town Clayton  
(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.  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah May Gibson

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced no

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 66 Months 10 Days 25 If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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 MO (b) County Clare  
(c) City or town Alexandria RR  
(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.

19. DATE OF DEATH Month Jan day 27  
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on 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 J. L. McConnell M. D. or other. Address Reverse Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

