DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31132

Registration District No. 89 | Primary Registration District No. 5131 | Registrar's No. 389

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

1. PLACE OF DEATH:
(a) County: BUTLER
(b) City or town: RURAL (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 years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: BUTLER
(c) City or town: RURAL (If outside city or town limits, write "RURAL")
(d) Street No.: 4 mi SW of POPLAR BLUFF MO (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: ROBERT GIBBS
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: Unknown
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Unknown (Month) (Day) (Year)

8. AGE: Years: Unknown | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
10. Usual occupation: LABORER
11. Industry or business: ____

MOTHER FATHER
12. Name: Unknown 9
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) ____ (State or foreign country)

16. (a) Informant: Eldon Palmer - Cousin
(b) Address: Poplar Bluff Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-2-41 (Month) (Day) (Year)
(c) Place: burial or cremation: COUNTY INFERMARY CEM.
18. (a) Signature of funeral director: N. T. Phelps
(b) Address: Poplar Bluff Mo
19. (a) 10-4-41 (Date received local registrar) (b) Belle Turner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 2 year: 1941 hour: 4 minute: a. M.
21. I hereby certify that I attended the deceased from Oct. 1, 1941, to Oct 2, 1941, that I last saw him alive on Oct. 1, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Indeterminate | Duration
Due to: ____
Due to: ____
Other conditions (Include 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? (Specify type of place)
While at work? (e) Means of injury: ____

23. Signature: Fred Biggs M.D. (M. D. or other)
Address: Poplar Bluff Mo. Date signed: 10-4-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED.
District Health Office No. 2
District File Number 10 41 - 13
Date Filed 10/8/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was NOT embalmed by me, or by .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed N. T. Phelps

Licensed Embalmer No. 3231

P. O. Address Poplar Bluff M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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21-41
K29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31132

Registration District No. 89 Primary Registration District No. 5131 Registrar's No. 380

1. PLACE OF DEATH:

(a) County: Butler

(b) City or town: Rural
(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Robert Gibbs

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

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

8. AGE: Years: Unknown Months Days If less than one day hr. 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) 10-4-41 (Date received local registrar) (b) Bellestinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1941 hour minute M.

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

Immediate cause of death Indeterminate

Duration

Due to probably starvation. Found in box car in unconscious condition xxx and never regained consciousness. Evidently been there several days when found.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 200b

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1941
S-31132