

FILED NOV 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 85424

Registration District No. 449

Primary Registration District No. 499-5664

Registrar's No. 5664

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

1. PLACE OF DEATH:

(a) County Linn
 (b) City or town Rural Clay Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community All his life!
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 058
 (c) City or town Rural Clay Township 0
(If outside city or town limits, write "RURAL")
 (d) Street No. Wheeling Route No. 1
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____ 0

3. (a) PRINT FULL NAME

Martin Timothy Gibson

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male 0

5. Color or

race White

6. (a) Single, widowed, married,

divorced Widower

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

February 2nd 1859

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

82

8

24

hr. min.

9. Birthplace

Linn Co. Missouri 0

(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Jacob Gipson

13. Birthplace Kentucky 1

(City, town, or county) (State or foreign country)

14. Maiden name Phoebe Ann Goode

15. Birthplace Kentucky 1

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Kirby

(b) Address Meadville Mo.

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 28 1941

(Month) (Day) (Year)

(c) Place: burial or cremation

Parson Crezk Cem.

18. (a) Signature of funeral director

Smiley Funeral Home

(b) Address

Wheeling Mo.

19. (a) 10/28-41

(Date received local registrar)

(b) Geo. H. Clark

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

Oct day 24

year 1941 hour _____ minute _____

A.M.

21. I hereby certify that I attended the deceased from

Oct 24

1941 to

Oct 26

1941

that I last saw him alive on

Oct 24

1941

and that death occurred on the date and hour stated above.

Immediate cause of death

yeasania

Duration

Due to

Enlarged Prostate gland, etc

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____ 0

Of autopsy _____ 0

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature W. H. Missigone (M. D. or other) 10

Address Wheeling Mo Date signed 10/28-41

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.....

Frank L Smiley

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Frank L. Smiley

Licensed Embalmer No.....

470

P. O. Address.....

Wheeling W. Va.

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.

Registration District No. **499**

Primary Registration District No. **5664**

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn
(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 _____)
In this community _____
years, months or days

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 Martin J. Gibson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct Day 26
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
_____ 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 2 185
(Month) (Day) (Year)

Duration _____
Physician _____
Enlarged prostate gland
Chronic nephritis

8. AGE: Years 82 Months 8 Days 30 If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation _____
11. Industry of business _____

Major findings:
Of operations _____
Of autopsy _____

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)

1318
Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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 _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

32154

1948

100

S-35424

100

100