

JAN 7 1942

Registration District No. 900

Primary Registration District No. 6257

Registrar's No.

1. PLACE OF DEATH:

(a) County Weberster
(b) City or town Wagon Wheel
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 year
In this community 2 year
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Weberster
(c) City or town Rural
(d) Street No. Wagon Wheel Rural
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Benjamin F. Gibbons

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 Married

6. (b) Name of husband or wife Lois Gibbons

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased June 2 1875
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation Interior decorator

11. Industry or business BY LICENSED EMBALMER

12. Name Samuel Gibbons

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

14. Maiden name Priscilla Brown

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

16. (a) Informant Mrs Lois Gibbons

(b) Address Wagon Wheel RFD 2

17. (a) Burial (b) Date, thereof Jun 1 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myrtle Hill Ceme

18. (a) Signature of funeral director Kelley Serrell

(b) Address Wagon Wheel

19. (a) Dec 30 1941 (b) W. F. Schlicht
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1941 hour 2:45 minute P.M.

21. I hereby certify that I attended the deceased from Dec 1 - 1941
Dec 29, 1941 to Dec 29, 1941;
that I last saw him alive on Dec 29, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency
Due to Chronic Valvular heart disease
Due to

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations 92 b
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)
(a) Means of injury DoF
23. Signature W. F. Schlicht (M. D. or other)
Address Wagon Wheel Mo Date, signed 1/14

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

17
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11w ylp

42

12-30-41

2751
6 NOV

JAN 3 1942

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 *W H Kelley*

Licensed Embalmer No. *3334*

P. O. Address *Henryous and*

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.