

FILED OCT 20 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3672

48  
968

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

1. PLACE OF DEATH: Jackson

(a) County Kansas City

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution. 6 hrs  
(Specify whether years, months or days)

In this community 6 hrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. K.C. 521 1/2 E. 12th St.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Gibson infant

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife ---

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

7. Birth date of deceased June 15th 1942  
(Month) (Day) (Year)

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

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

10. Usual occupation infant

11. Industry or business ---

MOTHER FATHER { 12. Name Robert Ernest Gibson

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

14. Maiden name Helen Ann Smith

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

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof June 15th 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lees Summit

18. (a) Signature of funeral director M. M. Crowe

(b) Address City

19. (a) 10-6-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15th  
year 1942 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from 6-15-42, 19, to 6-15-42, 19,  
that I last saw h. im alive on 6-15-42, 19,  
and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURITY

Due to 159

Due to ---

Other conditions ---  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: ---  
Of operations ---

Of autopsy None

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 --- Means of injury ---

23. Signature Dr. R. J. ... (M. D. or other) ---  
Address Med. Bldg. K.C. Gen. Hospital, K.C., Mo. signed ---

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**