

S. No. 2
M-5-43
v. 5-17-39
p. 1 X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8254
Registrar's No. 562

Registration District No. 317 Primary Registration District No. 3063

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis County Hospital
(d) Length of stay: In hospital or institution 5 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Maplewood
(d) Street No. 2818 Laclede Station Road
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Harrison Gibson
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 Catherine Gibson
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased April 2, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 11 0 hr. min

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name James Gibson
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Gilla Florence Week
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Catherine Gibson
(b) Address 2818 Laclede Sta. Rd. Maplewood, Mo.

17. (a) Burial (b) Date thereof Mar. 5, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cem, St. James, Mo.

18. (a) Signature of funeral director Jay B. Smith
(b) Address 7456 Manchester, Maplewood, Mo.

19. (a) MAR 6 - 1944 (b) E. J. no Davran, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-2-44 day 1:50 hour P. minute M.
21. I hereby certify that I attended the deceased from 2-26-44, 19 , to 3-2-44, 19 ;
that I last saw him alive on 3-2-44, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of colon, metastatic. Typh. Peritonitis, generalized.
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

Major findings: (1942) Carcinoma of rectum
Of operations _____
Of autopsy Carcinoma of colon w/lymph nodes, peritonitis.

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) (c) Means of injury _____

23. Signature James G. Owen M.D. (M. D. or other) _____
Address 601 Brentwood Blvd, Clayton Date signed 3-3-44

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 3454

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.