

FILED JUL 8 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

Jackson
(a) County
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 28 days
(Specify whether
In this community 72 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
6722 Bales (If outside city or town limits, write "RURAL") 8
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Gibbens Emma

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William H. Gibbens 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased March 18 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Harlem Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER

12. Name John G. Zimmerman 4
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Kern
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant William H. Gibbens
(b) Address 6722 Bales Avenue

17. (a) Burial (b) Date thereof 6/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (c) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 6-22-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1944 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from May 24 1944 June 21 1944
that I last saw her alive on June 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Poss. Septicemia pending further investigation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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) Means of injury

23. Signature A. E. Upsher M.D. or other
Address Date signed

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. *July*
Registrar's No. *2619*

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: *San Hospital*
(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

3. (a) PRINT FULL NAME: *Emma Libbens*

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years _____ 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 _____

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) _____ (b) Date thereof: _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

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) If foreign born, how long in U. S. A. _____ years.

20. DATE OF DEATH: Month *June* day *21*
year _____ 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: *Possible Septicemia*
Due to: *Multiple septic infarcts of kidney & spleen, primary source not known.*

Major findings: *133/5*
Of operations _____
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? _____

23. Signature: *A. E. Upsher MD* (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTAL

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

20022