

X29484

FILED JUL 10 1944

Primary Registration District No. **3018**

Registrar's No. **45**

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

**1. PLACE OF DEATH:** *Dent.*

(a) County *Dent.*

(b) City or town *Salem.*  
(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 *1*  
years, months or days

In this community *18* years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State *Mo.* (b) County *Dent. 33*

(c) City or town *Salem.*  
(If outside city or town limits, write "RURAL")

(d) Street No. *1*  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** *Delbert Gear Gibbs.*

(b) If veteran, name war *✓*

3. (c) Social Security No. *✓*

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month *June 27* day *27*th  
year *1944* hour *1* minute *0* M.

21. I hereby certify that I attended the deceased from *June 27*, 19*44* to *June 27*, 19*44*  
that I last saw *him* alive on *June 27*, 19*44*  
and that death occurred on the date and hour stated above.

4. Sex *M*<sup>0</sup> 5. Color *W*

6. (a) Single, widowed, married, divorced *S*<sup>0</sup>

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive *29* years (Day) (Year)

7. Birth date of deceased *Aug 29 1931*  
(Month) (Day) (Year)

Immediate cause of death *Pertussis*

Duration *Unknown*

**8. AGE:**

Years	Months	Days	If less than one day
<i>12</i>	<i>9</i>	<i>28</i>	hr. min.

9. Birthplace *Dent Co. Mo 0*  
(City, town, or county) (State or foreign country)

Due to *ruptured appendix*

Due to

Other conditions *12/1/1*  
(Include pregnancy within 3 months of death)

10. Usual occupation:

11. Industry or business:

12. Name *Raymond Gibbs*

13. Birthplace *Dent Co. Mo 0*  
(City, town, or county) (State or foreign country)

14. Maiden name *Lola Wright*

15. Birthplace *Dent Co. Mo 0*  
(City, town, or county) (State or foreign country)

Major findings: Of operations *12/1/1*

Of autopsy

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

16. (a) Informant *Mrs. Lola Plank*

(b) Address *Salem Mo*

17. (a) *Burial* (b) Date thereof *6-29-44*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *June Cemetery*

18. (a) Signature of funeral director *Robert Prantham*

(b) Address *Salem Mo*

19. (a) *6-28-44* (b) *Jas. H. McLeod by MCG*  
(Date received local registrar) (Registrar's signature)

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 *0*

23. Signature *E. E. Joseph* (M. D. or other) *MD*  
Address *Salem, Mo.* Date signed *6/27/44*

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RECEIVED

District health Officer No. 5,

District File Number 744393

Date Filed 7-8-44

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.....

*me*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Oral E. Lickliker*

Licensed Embalmer No. *3546*

P. O. Address *St James 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.