

FILED JUN 20 1944 102  
Registration District No.

Primary Registration District No. 4174

Registrar's No.

1. PLACE OF DEATH:  
(a) County Dunklin  
(b) City or town Cardwell  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution English Clinic  
(If not in hospital or institution, write street number or location) 18 days  
(d) Length of stay: In hospital or institution 18 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Dunklin  
(c) City or town Cardwell, (Leachville Ark. County)  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ARTIE MAE GIBSON  
3. (b) If veteran, name war ✓  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 17th  
year 1944 hour 4 minute 45 A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw her alive on 5-16-44 \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
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 May 4 1910  
(Month) (Day) (Year)

Immediate cause of death Intestinal obstruction  
Duration 3 days  
Due to operation in ruptured & gangrenous appendix 21 days  
Due to \_\_\_\_\_

8. AGE: Years 14 Months 0 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions 12/11  
(Include pregnancy within 3 months of death)  
Major findings: Appendix gangrenous, ruptured & many adhesions  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER

9. Birthplace Leachville, Ark.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Student  
11. Industry or business \_\_\_\_\_  
12. Name D. P. Gibson  
13. Birthplace Uma, Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mice Pruitt  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
16. (a) Informant D. P. Gibson  
(b) Address Leachville Ark R. 70 #1  
17. (a) Burial (b) Date thereof 5/19/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cardwell, Mo.  
18. (a) Signature of funeral director W. H. Howard  
(b) Address Leachville Ark.  
19. (a) June-44 (b) M. M. Moon  
(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?  
(Specify type of place)  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. W. English (M. D. or other) \_\_\_\_\_  
Address Cardwell, Mo. Date signed 5-20-44

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

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

005

1,013

RECEIVED

District Health Office No. 2,

District File Number 644-888

Date Filed 6-14-44

INDUSTRIAL BAIL BATH

**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. Howard

Licensed Embalmer No. 3959

P. O. Address Leakwell Ave

**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.