S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30795

Registration District No. 82 | Primary Registration District No. 3017 | Registrar's No. 166

1. PLACE OF DEATH
(a) County: Cooper
(b) City or town: Bonneville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: In home of negro residence - East Boonville Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: — (Specify whether years, months or days)
In this community: —

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Howard 45
(c) City or town: New Franklin 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 1

3. (a) PRINT FULL NAME: STERLING HAYNORTH GIBSON
3. (b) If veteran, name war:
3. (c) Social Security No. 702-10-8257
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Deceased
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Mar. (Month) 18 (Day) 1885 (Year)

8. AGE: Years 59 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace: Howard Co., Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Section Laborer
11. Industry or business: MK&T R.R. Co.
12. Name of father: Frank Gibson
13. Birthplace of father: Howard Co. Mo (City, town, or county) (State or foreign country)
14. Maiden name of mother: Unknown
15. Birthplace of mother: " (City, town or county) (State or foreign country)
16. (a) Informant: Lydia Effie Gibson
(b) Address: 3618 Lafayette, St. Louis Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-31-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Bethel
18. (a) Signature of funeral director: [illegible]
(b) Address: New Franklin Mo.
19. (a) Aug 31-44 (Date received local registrar) (b) Dr Chas Swap, (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1944 hour 4 minute P.M.
21. I hereby certify that I attended the deceased from Aug 28, 1944 to Aug 28, 1944 that I last saw him alive on Aug 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: apoplexy cerebral Haemorrhage — Duration: 1 day
Due to: Hypertension
Due to:
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings: —
Of operations:
Of autopsy: —

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) (e) Means of injury:
23. Signature: L. L. Chamberlain (M. D. or other)
Address: New Franklin Mo. Date signed: Aug 30-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number

Date Filed 10-10-44

OCT 24 1945

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 G. L. Lee

Licensed Embalmer No. 3515

P. O. Address New Franklin 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.