

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 4774

FILED DEC 9 1944
149

Registration District No. _____ Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Osteopathic Hospital - 11th & Harrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 312 No. Wheeling Ave.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Henry A. Gibbons

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 4 7 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>7</u>	<u>17</u>	_____ hr. _____ min.

9. Birthplace Decatur, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Mail carrier

11. Industry or business U. S. Post office

12. Name Robert Emmett Gibbons

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Alice Johnson

15. Birthplace Louisville, Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Gibbons

(b) Address 314 No. Wheeling

17. (a) burial (b) Date thereof 11-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 11-27-44 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24
year 1944 hour 12 minute 02 P. M.

21. I hereby certify that I attended the deceased from Nov. 19, 1944 to Nov. 24, 1944
that I last saw him alive on Nov. 24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Decompensated myocarditis
Due to Uremia

Due to Hypertrophied prostate
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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? _____

While at work? _____ (Specify type of place) (b) Means of injury _____
23. Signature J. J. Gocik (M.D. or other) DO
Address 5902 St. John Date signed 11/24/44

Duration

2 days

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. J. J. Pocsik
5902 St. John

Any time this P M

APR 20 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 John P. Sheil

Licensed Embalmer No. 3625

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.