

FILED JAN 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41512
Registrar's No. 406

Registration District No. 187

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 _____ (Specify whether)
In this community 66 Yrs years, months or days

3. (a) PRINT FULL NAME Clyde Gibson

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

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

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

7. Birth date of deceased NOV 7 1883 (Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Bedford Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Cook restaurant

12. Name Clyde Gibson
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Addie Ferguson
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Joe Young blood

(b) Address Brookfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Roze Hill Cemetery

18. (a) Signature of funeral director Wm. H. Borden

(b) Address Brookfield Mo.

19. (a) 12-28-44 (b) W H Cannon (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Brookfield (If outside city or town limits, write "RURAL")
(d) Street No. 202 E Canal (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27th
year 1944 hour 5 minute 10 P M.

21. I hereby certify that I attended the deceased from Sept 20 1944 to Dec 26 1944
that I last saw him alive on Dec 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDIAL FAILURE Duration 3 days

Due to SYPHILIS

Due to 309

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 2

23. Signature Dr. W. H. Cannon (M. D. or other) Dr.
Address Brookfield Mo. Date signed 12-28-44

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.