

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 25 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Green

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

(c) Name of hospital or institution:
Pythian Home, 6275 Campbell
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months
(Specify whether years, months or days)

In this community 6 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Green

City or town Springfield Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 6278 Campbell St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

8. (a) PRINT FULL NAME Wm Henry Gibbons

8. (b) If veteran, name war UNK.

8. (c) Social Security No. UNK.

4. Sex male race white

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased July 23, 1859
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4th
year 1945 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 26, 1944, Jan 4, 1945
that I last saw him alive on Jan 4, 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<u>v</u>	<u>85</u>	<u>5</u>	<u>11</u>	<u>or</u> _____ <u>min.</u>

9. Birthplace Stilesville Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Welfare Worker

11. Industry or business _____

Immediate cause of death Influenza
Due to Secondary

Due to _____

Other conditions Chronic Asthma
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name J. H. Gibbons

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

14. Maiden name Unknown

15. Birthplace Unknown UNK.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oliver Wakeman

(b) Address 629 S. Campbell, Spfld

17. (a) Removal (b) Date thereof Jan 5 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo

18. (a) Signature of funeral director Ered P. Phemong

(b) Address 1100 Boonville, St. Spfld

19. (a) 1-5-45 (b) S. W. S. Handley
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations 33

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Duration _____

(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 William R. Beiter (M. D. or other) 15-45

Address 38 Med Art Bldg Date signed 1-5-45

Duration Weeks

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 1 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 Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, 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, above space should be left blank.

X ✓