

No. 2
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5-17-39
F. X35937

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40735**
Registrar's No. **391**

Registration District No. **47** Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Callaway Co. Hospital**
(If not in hospital or institution, write street number & location) **3 Days**
(d) Length of stay: In hospital or institution **50 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOSEPHINE ROGERS GIBONEY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Fe.** 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **George** 6. (c) Age of husband or wife if alive **30** years **1877**
7. Birth date of deceased: **June 30** (Month) (Day) (Year)

8. AGE: Years **68** Months **5** Days **13** If less than one day hr. min.

9. Birthplace **Audraing Co Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Rogers**
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)
14. Maiden name **Caroline Floyd**
15. Birthplace **Ill.** (City, town, or county) (State or foreign country)

16. (a) Informant **George Giboney**
(b) Address **Fulton, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-15-45** (Month) (Day) (Year)
(c) Place: burial or cremation **Pioneer Cem**

18. (a) Signature of funeral director **Hallace Funeral Home**
(b) Address **Fulton, Mo.**
19. (a) **1213-1945** (Date received local registrar) (b) **Joan Mossack** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Callaway 14**
(c) City or town **Fulton** (If outside city or town limits, write "RURAL")
(d) Street No. **R. F. D. # 3** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **13** year **1945** hour **7** minute **15 A.M.**
21. I hereby certify that I attended the deceased from **Dec 8th** to **Dec 13** 19**45** that I last saw her alive on **Dec** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death: **Acute Myocarditis**
Due to **intestinal obstruction**

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? _____

(Specify type of place) _____ (c) Means of injury _____
23. Signature **George J. Wood** (M. D. or other) **Dr**
Address **Fulton 910** Date signed **12/15/45**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 1-14-46

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 Benjamin C. Browning
Licensed Embalmer No. 2724
P. O. Address Fulton 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.

Registration District No. *47*Primary Registration District No. *3008*

1. PLACE OF DEATH:

(a) County *Callaway*
(b) City or town *Zulchen*
(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 _____
years, months or days)3. (a) PRINT
FULL NAME *Josephine R. Giboney*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*

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

7. Birth date of deceased *June 30*
(Month) (Day) (Year)8. AGE: Years *68* Months _____ Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) *M.O.*

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year *1960* hour _____ minute _____ M. *3*

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to *Cancer - Pleural Metast*

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy *462*

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

40735