5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8479

Registration District No. 32 Primary Registration District No. 5111 Registrar's No. 23

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town rural Liberty Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town rural (If outside city or town limits, write "RURAL")
(d) Street No. Near Brownwood (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HENRY ALBERT GIPSON
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased June 14 1892 (Month) (Day) (Year)
8. AGE: Years 53 Months 8 Days 2 If less than one day hr. min.
9. Birthplace Stoddard Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name John Gipson
13. Birthplace not known (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country)
16. (a) Informant Delas Gipson
(b) Address Brownwood, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Brownwood Cem
18. (a) Signature of funeral director [illegible] S. Morse
(b) Address [illegible] Mo.
19. (a) Mar 18 1946 (Date received local registrar) (b) Willie H. Cruikshank (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16 year 1946 hour 7 minute 45 P.M.
21. I hereby certify that I attended the deceased from ...., 19...., to ...., 19....; that I last saw h.... alive on ...., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Suicide	
Due to Gunshot wound through heart	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)
While at work? (e) Means of injury
23. Signature [illegible] Coroner M.D. or other
Address [illegible] Date signed 3/5/46

25

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 446-1914

Date Filed 4-8-46

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.....

Lloyd S. Morgan, Registered Apprentice No.....,

working under my personal supervision.

Signed Lloyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, 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.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Copied

Registration District No. 32 Primary Registration District No. 5111 Registrar's No.

1. PLACE OF DEATH:

(a) County Bollinger

(b) City or town Rural
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 23

(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

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

3. (b) If veteran, name war

3. (c) Social Security No.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 14 (Day) 18 (Year)

8. AGE: Years 53 | Months 8 | Days | Unless less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name

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

MOTHER
14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY year 1946 hour minute M.

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

Immediate cause of death — *Duration*
Gun shot through heart

Due to

Due to

ADDITIONAL SUPPLEMENTARY INFORMATION NEEDED

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) Suicide

(b) Date of occurrence 2/16/46

(c) Where did injury occur? Bollinger Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place)

While at work? (e) Means of injury

23. Signature John J. Myers (M.D. or other)

Address Sikeston Mo Date signed 4/8/46

SUPPLEMENTARY

8479