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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 21 1946

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 36652

Registrar's No. 885

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: 1310 West Florida
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene. 39

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

(d) Street No. 1310 West Florida
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Charles L.Gibson Jr.

3. (b) If veteran, name war 2 ond.World

3. (c) Social Security No. ? ? yes

4. Sex M O

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Loise June Gibson

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased December (Month) 2 (Day) 1922 (Year)

8. AGE: Years 23 Months 11 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace New Madrid Co. (City, town, or county) Mo. (State or foreign country) O

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Charles L. Gibson Sr.
13. Birthplace No.3 Island (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Mary Alma Brees
15. Birthplace Essex (City, town, or county) Mo. (State or foreign country) O

16. (a) Informant Charles L.Gibson Sr.

(b) Address 1310 West Florida, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director W.L.Dunn

(b) Address Springfield, Mo.

19. (a) 11-5-46 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 5 th.
year 1946 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from 11-4, 1946, to 11-5, 1946;
that I last saw him alive on 11-4, 1946;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	36 hr
Due to	
Due to 108	
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)

While at work? (e) Means of injury O

23. Signature [signature] (M. D. or other)

Address [illegible] Mo. Date signed 11-5-46

111

(Licensed Embalmer's Statement on Reverse Side)

JUL 15 1947

NOV 7 1946

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 D. L. McCann

Licensed Embalmer No. 7777

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, fact should be so stated above.