S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20770

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 32

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days (Specify whether
In this community All her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45
(c) City or town Glasgow, (Rural) 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. ---- 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -----

3. (a) PRINT FULL NAME Berta M. Gibbs
3. (b) If veteran, name war ----
3. (c) Social Security No. ---
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Wade Maupin
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased February (Month) 15, (Day) 1887 (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	3	17	hr. -- min.

9. Birthplace Howard Co. Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business -----
FATHER
12. Name Thomas A. Gibbs 0
13. Birthplace Carrol Co. Missouri
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Lou Routt 0
15. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Thos. E. Gibbs
(b) Address Glasgow, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Green
18. (a) Signature of funeral director Ralph A. Carr
(b) Address Fayette, Missouri
19. (a) 6-7-1947 (Date received local registrar) (b) Dorothy Fernfahrer Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd year 1947 hour 4:45 minute A. M.
21. I hereby certify that I attended the deceased from May 14 3 1947, to June 2 1947, that I last saw her alive on June 2 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Melano Carcinoma	3 yrs.
Due to	
Due to	
Other conditions Metastasis to spine (Include pregnancy within 3 months of death)	3 mos.

ADDITIONAL SUPPLEMENTARY INFORMATION

Major findings: Of operations none
Of autopsy none

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? 0
(Specify type of place)
While at work? (e) Means of injury
23. Signature Wm J Shaw (M. D. or other) MD
Address Fayette Mo. Date signed 6-5-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 6-16-47

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 Floyd O Jaspering, Registered Apprentice No. 461, working under my personal supervision.

Signed Ralph A Carr

Licensed Embalmer No. 3340

P. O. Address Fayette 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.

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. July

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 32

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Fayette
(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)

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

3. (a) PRINT FULL NAME Berta M. Gibbs

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 Dev

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 15 (Day) 1888 (Year)

8. AGE: Years 60 Months 3 Days 17 If 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 June 2 day
year 1947 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
Cerebral embolus	2 days
Due to Melano-carcinoma	2 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 55B
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

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

Address Date signed

SUPPLEMENTARY

S-20770