No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27352

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 776

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: 2408 N. Newton Ave., 1
(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:
(a) State: Mo. (b) County: Greene 39
(c) City or town: Springfield
(If outside city or town limits, write "RURAL")
(d) Street No.: 2408 N. Newton Ave., 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Sarah Grace Giboney
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. SEX: FEMALE 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: William Harvey Giboney
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: August (Month) 5 (Day) 1882 (Year)

8. AGE: Years 65 | Months 0 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: Jasper County (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation: House wife
11. Industry or business: At home
FATHER
12. Name: William J. Johnson
13. Birthplace: Nashville (City, town, or county) Tenn. (State or foreign country) 1
MOTHER
14. Maiden name: A. E. McCurdy
15. Birthplace: Barton County (City, town, or county) Mo. (State or foreign country) 0
16. (a) Informant: Earl Giboney
(b) Address: 2408 N. Newton Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 4-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Comfort Cem.
18. (a) Signature of funeral director: J. W. Klingner & Co.
(b) Address: Springfield Mo.
19. (a) 9-3-47 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 2, year 1947 hour 2 minute 55 A. M.
21. I hereby certify that I attended the deceased from Feb, 1947, to 9-2-47, 19____; that I last saw her alive on 9-1-47, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of Stomach — Duration: 4 mo.
Due to ____
Due to ____
Other conditions (Include pregnancy within 3 months of death) ____
Major findings: Of operations: 46 PO
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? ____
While at work? (Specify type of place) (e) Means of injury: 0

23. Signature: [illegible] M.D. (M. D. or other)
Address: Springfield Mo. Date signed 9-2-47

(Licensed Embalmer's Statement on Reverse Side)

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 Mark Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.