

FILED FEB 6 1948

Registration District No. **128**

Primary Registration District No. **2000**

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: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 hr. 45 Minutes**
(Specify whether
In this community **1 Hour 45 Minutes**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Greene**
(c) City or town **Springfield - Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **1537 Drury St., Rt. 6 Box 2751**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Phyllis Fay Gibson**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **January 23 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 1 hr. 45 min.

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

10. Usual occupation **Infant**

11. Industry or business **At Home**

MOTHER FATHER

12. Name **Gene Gibson**
13. Birthplace **Springfield Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Hazel E. Shull**
15. Birthplace **Greene County Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gene Gibson Springfield Mo**
(b) Address **R. F. # 6.**

17. (a) **Burial** (b) Date thereof **1-25-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Danforth Cem.**

18. (a) Signature of funeral director **J. Klingner & Co.**
(b) Address **Springfield Mo.**

19. (a) **1-26-48** (b) **W. E. Huskey MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **23**,
year **1948** hour **2** minute **30** P. M.
21. I hereby certify that I attended the deceased from **1 PM**
1-23 1948, to **7:30 1-23-1948**
that I last saw **her** alive on **1:30 pm 1-23-1948**
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death
Premature del 4 new gestation

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place) Means of injury
23. Signature **C. E. Teller** (M. D. or other)
Address **Springfield Mo.** Date signed **1-23-48**

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.