

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18813**
Registrar's No. **218**

FILED JUL 13 1948

Registration District No. **23**

Primary Registration District No. **5139**

1. PLACE OF DEATH:

(a) County **BUTLER**
(b) City or town **STAR ROUTE NEELYVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **STAR ROUTE HOME**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 YEARS** (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **BUTLER**
(c) City or town **STAR ROUTE**
(If outside city or town limits, write "RURAL")
(d) Street No. **NEELYVILLE**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **FLOSSIE MAE GIBSON**

3. (b) If veteran, name war **X** 3. (c) Social Security No.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (b) Name of husband or wife **HUGHIE GIBSON** 6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **MAY 24 1915** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 1 6 hr. min.

9. Birthplace **ADVANCE MO.** (City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **HOME**

12. Name **HENRY C. CHIDESTER**

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

14. Maiden name **PEARL SANDERS**

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

16. (a) Informant **Hughie Gibson**
(b) Address **Star Route Neelyville Mo.**

17. (a) **BURIAL** (b) Date thereof **7-2-48** (Month) (Day) (Year)
(c) Place: burial or cremation **SIMS CEMETERY**

18. (a) Signature of funeral director **K. J. Selig**
(b) Address **Black's Mortuary Springfield**

19. (a) **7/8/48** (b) **[Signature]** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **30** year **1948** 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 **Coronary Heart Disease** Duration **1 1/2 years**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **[Signature]**

Of autopsy **None**

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 **3**

23. Signature **[Signature]** Address **Springfield Mo.** Date signed **7/7-48**

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 242-858

Date Filed 2-12-48

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 Roman J. Selig Jr.

Licensed Embalmer No. 5762

P. O. Address Conning, Ark

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.