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M-10-47  
Ev. 5-17-39  
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41472

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED JAN 11 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

11006

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
St. Louis City Hospital  
(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 Missouri (b) County Jan

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4963 Rosalie Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Esco Gibbs

3. (b) If veteran name war World War I | 3. (c) Social Security No. Unknown

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Laura Gibbs | 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 14 1889  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>10</u>	<u>5</u>	hr. _____ min.

9. Birthplace Steeleville Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Druggist

11. Industry or business \_\_\_\_\_

12. Name M.P. Gibbs

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Myra Scott

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Gibbs  
(b) Address 4963 Rosalie Ave.

17. (a) Burial (b) Date thereof 12-22-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steeleville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
19. (a) DEC 20 1948 (b) J. B. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec. day 19 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1948 to Dec 19 1948 that I last saw him alive on Dec 19 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Intra-cranial hemorrhage & Hemiplegia Duration 12-14 hrs

Due to Arterio-sclerotic hypertension

Due to coronary vascular renal disease 10 yrs.

Other conditions (Include pregnancy within 3 months of death) 12/21

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature C. N. Lindeman (M. D. or other) MD  
Address 1720/48 Date signed 12/20/48

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

MOTHER FATHER

MAY 3 1949

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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 Gustav W Ditzel

- - Licensed Embalmer No. 4329

. . P. O. Address St. Louis, 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.**