

No. 300
10-48

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 663

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5379 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY De Kalb
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarkdale Rural
c. LENGTH OF STAY (In this place) 10 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 3 MI North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY De Kalb
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarkdale Rural
d. STREET ADDRESS (If rural, give location) 3 mile north

3. NAME OF DECEASED
a. (First) Lynwood b. (Middle) Franklin c. (Last) Gibson
4. DATE OF DEATH (Month) (Day) (Year) Jan 15 50

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Aug. 5 1876
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR: Months 5 Days 10 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farm 11. BIRTHPLACE (State or foreign country) Mo 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Gibson 13b. MOTHER'S MAIDEN NAME Mary Howery 14. NAME OF HUSBAND OR WIFE Bertha Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Bertha Gibson ADDRESS Clarksdale Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart condition
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. #

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) _____ (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.

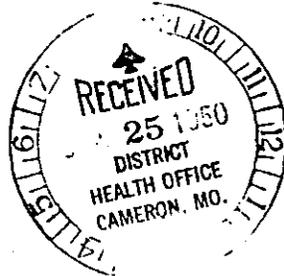
23a. SIGNATURE M. S. Gail, M.D., Coroner (Degree or title) 23b. ADDRESS O. Coroner Mo 23c. DATE SIGNED Jan 16 50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Jan 17 50 24c. NAME OF CEMETERY OR CREMATORY Memorial Park 24d. LOCATION (City, town, or county) (State) St. Joseph Mo

DATE REC'D BY LOCAL REG. 1-15-50 REGISTRAR'S SIGNATURE Rose Davidson 820 FUNERAL DIRECTOR'S SIGNATURE John Brown 820 ADDRESSES Wayville Mo

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

(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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

John Brown

Signed.....

Student Embalmer

Licensed Embalmer No. *3933*

P. O. Address *Mayville 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.