

FILED APR 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14547

State File No. 3251  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>2129</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>0</u>	
c. LENGTH OF STAY (in this place) <u>3yrs</u>		d. STREET ADDRESS (If rural, give location) <u>12 -- 5351 Delmar</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Masonic Home of Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mrs. Maud</u> b. (Middle) <u>Ross</u> c. (Last) <u>Gibson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 7 1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow 2</u>	8. DATE OF BIRTH <u>7/31/1879</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Champaign Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Claudious L. Ross</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Parrott</u>	
14. NAME OF HUSBAND OR WIFE <u>John Wright Gibson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>194-24-9581</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Masonic Home of Missouri</u>		ADDRESS <u>351 Delmar St. Louis, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Valvular Heart Disease</u> ANTECEDENT CAUSES <u>Chronic Interstitial Nephtitis</u> DUE TO (b) <u>Chronic Interstitial Nephtitis</u> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) (COUNTY) (STATE) <u>592X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4/20, 1948</u> , to <u>4/7, 1950</u> , that I last saw the deceased alive on <u>4/7, 1950</u> , and that death occurred at <u>4:30 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Dr. J. B. Suster</u>		23b. ADDRESS <u>508 Grand</u>	
23c. DATE SIGNED <u>4/7/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/10/50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontain Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>APR 7 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Suster</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred S. S. S. S.</u>		ADDRESS <u>6175 Delmar</u>	

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed James E. McCulloch

Licensed Embalmer No. 2466

P. O. Address 6175 Delmas

**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.