

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34827**
Registrar's No. **8609**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| c. LENGTH OF STAY (in this place) | | 2109 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital | | d. STREET ADDRESS (If rural, give location) 4276 Sullivan Avenue | |

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|--|---------------------------|-------------|----------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Mary | b. (Middle) | c. (Last) Gibson | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 7 1950 |
|--|---------------------------|-------------|----------------------------|--|

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|-------------------------|----------------------------------|--|--|--|--------------------------|-------------------------|-------------------------|------------------------|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Unknown About | 9. AGE (In years last birthday) 75 | # UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HR. Hours | IF UNDER 1 HR. Min. |
|-------------------------|----------------------------------|--|--|--|--------------------------|-------------------------|-------------------------|------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (State or foreign country) Robertson, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|---|--|

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|--|--|---|
| 13a. FATHER'S NAME Geo. Tucker | 13b. MOTHER'S MAIDEN NAME Mary Unknown | 14. NAME OF HUSBAND OR WIFE Alex Gibson |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Grace Grayson, 4315a Cozens Avenue | ADDRESS |
|--|-------------------------|--|---------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease | | Undet. |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Failure | | " |
| DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None | | | |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21d. 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) |
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|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? H2O |
|--|--|--|

22. I hereby certify that I attended the deceased from **10-6-50**, 10 to **10-7-50**, 1950; that I last saw the deceased alive on **10-7-50**, and that death occurred at **10:45 pm**, from the causes and on the date stated above.

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| 23. SIGNATURE Lorena Harkins M. D. | (Degree or title) | 23b. ADDRESS 2601 N Whittier St | 23c. DATE SIGNED 10-9-50 |
|--|-------------------|---|------------------------------------|

| | | | |
|---|------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 10/13/50 | 24c. NAME OF CEMETERY OR CREMATORY Greenwood | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
|---|------------------------------|--|---|

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| DATE REC'D BY LOCAL REG. OCT 12 1950 | REGISTRAR'S SIGNATURE J B Lesater | 25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue | ADDRESS |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed John K. Cunningham

Signed.....
Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.