

FILED AUG 17 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26243

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>2007</u>		Registrar's No. <u>343</u>	
1. PLACE OF DEATH a. COUNTY <u>BUTLER 0124</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BUTLER</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>POPLAR BLUFF</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>STAR ROUTE (COON ISLAND)</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>POPLAR BLUFF HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>NEELYVILLE 0130</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOE</u>		b. (Middle) _____		c. (Last) <u>GIPSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 1 1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8-20-1877</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>LEBANON IND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>CALVIN GIPSON</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY KENNEDY</u>		14. NAME OF HUSBAND OR WIFE <u>CLEMMIE C. (DECEASED)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>495-14-0971</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>MRS H.B. GRAHAM 901 ELEANOR KNOXVILLE, TENN.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-vascular accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>443X</u>					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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		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>7-19</u> <u>1951</u> , to <u>8-1</u> <u>1951</u> , that I last saw the deceased alive on <u>8-1</u> <u>1951</u> , and that death occurred at <u>8 p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W.E. Scumlein, B.S., M.D.</u>				23b. ADDRESS <u>Poplar Bluff Hospital</u>		23c. DATE SIGNED <u>8/2/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8-4-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>COON ISLAND CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>BUTLER Co., MO.</u>		
DATE REC'D BY LOCAL REG. <u>Aug 6 1951</u>		REGISTRAR'S SIGNATURE <u>Wm. H. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>R.J. Selig, Black's Notary, Spring, Ark.</u>			

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

RECEIVED

AUG 15 1951

BUTLER CO. HEALTH CENTER

FILE No. 851-378

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

*Roman J. Selig Jr.*

Licensed Embalmer No. 562

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.