

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33341

State File No. ....

FILED OCT 30 1951

BIRTH NO. ....		REG. DIST. NO. <u>137</u>		PRIMARY REG. DIST. NO. <u>3023</u>		Registrar's No. <u>530</u>			
1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cloir</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clinton</u>		c. LENGTH OF STAY (in this place) <u>days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Collins</u> <u>0930</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wetzel Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edgar</u>		b. (Middle) <u>Allen</u>		c. (Last) <u>Gibson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-15-51</u>			
5. SEX <u>Male</u> <u>D</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>9/27/1876</u>			
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months   Days		IF UNDER 24 HRS. Hours   Min.					
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			11. BIRTHPLACE (State or foreign country) <u>Monmouth Illinois</u> <u>1</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>John Gibson</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Patterson</u>		14. NAME OF HUSBAND OR WIFE <u>Estelle Gibson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Estelle Gibson, Collins Missouri</u>			ADDRESS	
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>Strangulation of bowels with gangrene</u> ANTECEDENT CAUSES <u>Surgery. Shock of surgery.</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Semility</u> DUE TO (c) <u>Semility</u> II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of small intestine</u> <u>-5702</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) (Min.)		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>10-7</u> , 19 <u>51</u> , to <u>10-15</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>10-15 AM</u> , 19 <u>51</u> , and that death occurred at <u>11:35</u> a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Florence Adair</u>				23b. ADDRESS <u>Clinton, Mo</u>		23c. DATE SIGNED <u>Oct 16/51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/17/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>		24d. LOCATION (City, town, or county) (State) <u>Osceola Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Oct-22-51</u>		REGISTRAR'S SIGNATURE <u>Florence Adair</u> <u>422</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Goodrich</u>		ADDRESS <u>Osceola Mo</u>			

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

0423

RECEIVED OCT 29 1951

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed OCT 29 1951

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Orceola 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.