

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41333**

FILED DEC 19 1951

Registrar's No. **1055**

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 5466		Registrar's No. 1055	
1. PLACE OF DEATH a. COUNTY Green				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo COUNTY Christian Co			
b. CITY OR TOWN Springfield Mo		c. LENGTH OF STAY (In this place) 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparta Mo			
d. FULL NAME OF HOSPITAL OR INSTITUTION Travelers Court, Spgfld, Mo				d. STREET ADDRESS (If rural, give location) Sparta Mo			
3. NAME OF DECEASED (Type or Print) Squire		a. (First) Franklin		b. (Middle) Gibson		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Dec 12 1951		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH May 1, 1876		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Not Known		13b. MOTHER'S MAIDEN NAME Not Known		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Birchel Gibson, Sparta, Mo			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 or 6 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis 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 <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) 334X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 12/4/51 , 19___, to 12/12/51 , 19___, that I last saw the deceased alive on 12/4/51 , 19___, and that death occurred at 6 a.m. , from the causes and on the date stated above.							
22a. SIGNATURE J. L. O. T. ... M.D. (Degree or title)				22b. ADDRESS Springfield, Mo.		22c. DATE SIGNED 12/14/51	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec 15, 1951		23c. NAME OF CEMETERY OR CREMATORY Sparta Cemetery		23d. LOCATION (City, town, or county) (State) Christian Co Mo	
DATE REC'D BY LOCAL REG. 11/14/51		REGISTRAR'S SIGNATURE 111 Deputy Faith Williamson Registrar		25. FUNERAL DIRECTOR'S SIGNATURE T. B. Chaffin Ozark Mo ADDRESS			

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

0390

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

T. B. Chaffin

Signed.....
Student Embalmer

Licensed Embalmer No. *2192*

P. O. Address *Ozark, 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.