

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29489

State File No.

DEPT. OF HEALTH
BIRTH NO. **SEP 3- 1952**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **7725**

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis 0**

c. LENGTH OF STAY (In this place township) **40 yrs.**

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Homer G. Phillips Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri**
b. COUNTY **2189**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis**

d. STREET ADDRESS (If rural, give location) **2927 Garrison Court**

3. NAME OF DECEASED (Type or Print)
a. (First) **Maude**
b. (Middle)
c. (Last) **Gibson**

4. DATE OF DEATH (Month) (Day) (Year)
August 9, 1952

5. SEX **Female**
6. COLOR OR RACE **Negro**
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widow 2**
8. DATE OF BIRTH **8/31/96**
9. AGE (In years last birthday) **55**
UNDER 1 YEAR Months Days
UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housework**
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) **Unknown Louisiana /**
12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Peter Lemons**
13b. MOTHER'S MAIDEN NAME **Temple Williams**
14. NAME OF HUSBAND OR WIFE **John Gibson**

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. **None**
17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Marie Mabin, 3404a Lawton Avenue**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Myocardial Infarction**
INTERVAL BETWEEN ONSET AND DEATH **Undetermined**

ANTECEDENT CAUSES
DUE TO (b) **Undetermined**
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 NO

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) **11:12 p.m.**
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? **4201**

22. I hereby certify that I attended the deceased from **Aug. 5, 1952** to **Aug. 9, 1952**, that I last saw the deceased alive on **August 9, 1952**, and that death occurred at **11:12 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Edna E. Brooks M.D.**
23b. ADDRESS **2601 N. Whittier St.**
23c. DATE SIGNED **August 11, 1952**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**
24b. DATE **8/13/52**
24c. NAME OF CEMETERY OR CREMATORY **Washington Park**
24d. LOCATION (City, town, or county) (State) **St. Louis Co., Missouri**

DATE REC'D BY LOCAL REG. **AUG 13 1952**
REGISTRAR'S SIGNATURE **J. Carl Smith M.D.**
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Chas J. Gates, 4107 Finney Avenue**

(Licensed Embalmer's Statement on Reverse Side)

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

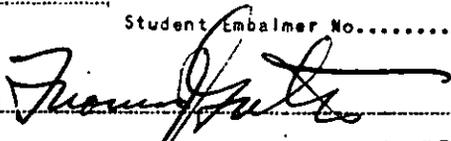
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4259

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.