

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

State File No. **18969**

FILED MAY 19 1953

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5987 Registrar's No. 47

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Pulaski	b. CITY (If outside corporate limits, write RURAL and give township) Rural Union	a. STATE Missouri	b. COUNTY Pulaski
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Rural Union <u>0850</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) Rosamond	b. (Middle)	c. (Last) Gibbons	(Month) 4	(Day) 30	(Year) 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/22/1893		9. AGE (In years last birthday) 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing General	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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. 489-20-5801	17. INFORMANT'S SIGNATURE OR NAME Mr. W. A. Gibbons, Dixon, Missouri

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		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of uterus</u>		
	ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>174 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 4-25, 1953 to 4-27, 1953, that I last saw the deceased alive on 4-27, 1953, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. D. Newitt, M.D.</u>	23b. ADDRESS <u>Waynesville, Mo.</u>	23c. DATE SIGNED <u>5-3-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <u>4/30/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Moberly Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>Moberly, Missouri</u>		

DATE REC'D BY LOCAL REG. <u>5-15-53</u>	REGISTRAR'S SIGNATURE <u>Paula ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred H. Gilbert</u>	ADDRESS <u>Dixon, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

0850
1

Date Filed 5-16-53

File No. _____

Public Health Officer _____

RECEIVED 5-15-53

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 _____

Not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address Dixon, Missouri

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.