

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27364**
3941

FILED SEP 7 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY HENRY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY OR TOWN CLINTON	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 YEAR		f. STREET ADDRESS (If rural, give location) X RURAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1310 EAST ARDOR BLVD. ELMS NURSING HOME			

3. NAME OF DECEASED (Type or Print)	a. (First) NETTIE	b. (Middle) G	c. (Last) HIBLER	4. DATE OF DEATH (Month) (Day) (Year) August 13, 1954
-------------------------------------	--------------------------	----------------------	-------------------------	--------------------------------------------------------------

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 6, 1877	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mts. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) 0 MONTROSE, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME W. A. GATES	13b. MOTHER'S MAIDEN NAME VIRGINIA BELL BLACK	14. NAME OF HUSBAND J. N. HIBLER
---------------------------------------	------------------------------------------------------	-----------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. PAUL M. MARSHALL	ADDRESS 139 EAST 56 THRD. KANSAS CITY, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Hypostatic		INTERVAL BETWEEN ONSET AND DEATH 4 days
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malnutrition		own
		DUE TO (c) Paraplegia (m.m.o.)		5 mo.
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Decubitus Ulcers.		over
				2 yr.
				352 X

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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

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 Mar 18, 1953, to Aug 13, 1954, that I last saw the deceased alive on Aug 13, 1954, and that death occurred at 6:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) Glen H. Broyles MD	23b. ADDRESS 1232 Professional Bldg	23c. DATE SIGNED 8-14-54
----------------------------------------------------------	--------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE AUG. 14, 1954	24c. NAME OF CEMETERY OR CREMATORY HOPEWELL CEMETERY	24d. LOCATION (City, town, or county) (State) CLINTON, MISSOURI
----------------------------------------------------------	--------------------------------	-------------------------------------------------------------	------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 8-14-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE M. F. Newcomer	ADDRESS 1331 BERRY CREEK KANSAS CITY, MISSOURI
-----------------------------------------	----------------------------------------------	--------------------------------------------------------	-------------------------------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Glen H. Broyles M.D.

03024420

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 Signature of Student Embalmer

Signed *Richard L. Rogers*

Licensed Embalmer No. 495

P. O. Address *Kansas*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.