

FILED SEP 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27709

318

1003

Registrar's No. 7377

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer Phillips Hospital</u>				STREET ADDRESS (If rural, give location) <u>4630 Enright</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Geneva</u>		b. (Middle) _____		c. (Last) <u>Gibbs</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 21 55</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 20, 1887</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>		IF UNDER 1 HRS. Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Lake Port Arkansas</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Mose Kennedy</u>		13b. MOTHER'S MAIDEN NAME <u>Goerganna Gibbs</u>		14. NAME OF HUSBAND OR WIFE <u>Charles</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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Leroy Bills 4542 N. Market</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardiovascular Dis.</u> ANTECEDENT CAUSES <u>Cardiac Insufficiency</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Chronic Brain Syndrome Asso. with Cerebral Arteriosclerosis</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Undt.</u>	
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) <u>4438</u>			
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 <u>8-9</u> , 19 <u>55</u> , to <u>8-21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-21</u> , 19 <u>55</u> , and that death occurred at <u>8:20a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Edw. B. Williams</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>2601 N. Whittier</u>				23c. DATE SIGNED <u>8-22-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8/25/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 23 1955</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Gates</u>		ADDRESS <u>4107 Finney</u>	

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 Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Arthur L. Hubbard*

Licensed Embalmer No. *422*

P. O. Address *4107 Elm*

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.