

FILED OCT 8 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

30390

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 892

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Greene		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		a. STATE Missouri		b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1231 N. Clay		Length of stay in lb 71 years		d. STREET ADDRESS (If outside, give location) 1231 N. Clay		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last MANNIE ROSELLA (BONHAM) GIBSON				Month Day Year October 1 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 29, 1868		9. AGE (In years last birthday) 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Leesburgs, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME J. K. Bonham				14. MOTHER'S MAIDEN NAME Unknown			
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 Address Miss Emma Gibson, Springfield, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency						2-wks.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Atherosclerotic Heart disease						10-yrs.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 2-1948 to 2-10-1-56 and last saw her/him alive on 10-1-56 Death occurred at 4:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Dr. M. K. Lingner M.D.				22b. ADDRESS 1630 N. Jefferson, Springfield Mo		22c. DATE SIGNED 10-3-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 3, 1956	23c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri		
24. FUNERAL DIRECTOR Jewell E. Windle			ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 10-3-56		26. REGISTRAR'S SIGNATURE Edith Williams

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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..... *Murray Wilson*
Licensed Embalmer No. *498*

P. O. Address *Springfield*

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.