

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31429
STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 907

300
1-57

1. PLACE OF DEATH a. COUNTY Greene County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
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 Marionville Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hosp. Springfield		Length of stay in lb 18 hrs.	d. STREET ADDRESS (If outside, give location) Route # 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LeRoy Middle Last Gibson	4. DATE OF DEATH Month Sept. Day 18, Year 1957
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5. SEX Male	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 March 6, 1902	9. AGE (In years) Last birthday 55	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steeple Jack	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Springfield, Illinois	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME John Gibson	13b. MOTHER'S MAIDEN NAME Hattie Harmon	14. NAME OF HUSBAND OR WIFE Laura Mae Gibson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 348-09-2009	17. INFORMANT Address Laura Mae Gibson, R 1 Marionville, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Follicular Lymphoma 9 mths		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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 checked="" type="checkbox"/> NO <input 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.) 2020
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from June 1957 to 18 Sept 1957 and last saw him alive on 17 Sept '57 Death occurred at 4:20 a. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Doctor or title) Francis M Maple MD	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 19 Sept '57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-18-57	23c. NAME OF CEMETERY OR CREMATORY I O O F Cemetery	23d. LOCATION (City, town, or county) (State) Marionville, Mo.
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24. FUNERAL DIRECTOR Bradford Burdige	ADDRESS Marionville, Mo.	25. DATE RECD. BY LOCAL REG. 9-20-57	26. REGISTRAR'S SIGNATURE Edith Williamson
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

SEP 23 1957

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 *Lewis G. Schaefer*

Licensed Embalmer No. *3802*

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.