

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001305

STATE FILE NUMBER

92

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JAN 21 1959

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Richmond	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Childrens Mercy		d. STREET ADDRESS (If outside, give location) RA #1	
3. NAME OF DECEASED (Type or print) First Middle Last Norman Franklin Gibson		4. DATE OF DEATH Month Day Year 1-6-59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-57
9. AGE (In years last birthday) 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (City and state or country) Carrollton Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Nelson Gibson		13b. MOTHER'S MAIDEN NAME Fannie Cobb	
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. none		17. INFORMANT Nelson Gibson RR 1 Dist. Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Reticulo endotheliosis DUE TO (c) 2021			INTERVAL BETWEEN ONSET AND DEATH 1 yr
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.)	
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	
21. I attended the deceased from 9-15-58 to 1-6-59 and last saw him alive on 1-6-59 Death occurred at 10:02 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) [Signature]		22b. ADDRESS 1710 Independence Ave. Kansas City Mo	
22c. DATE SIGNED 1-6-59		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-7-59	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Chellicotte Mo	
24. FUNERAL DIRECTOR [Signature] ADDRESS		25. DATE RECD. BY LOCAL REG. 1-7-59	
26. REGISTRAR'S SIGNATURE [Signature]			

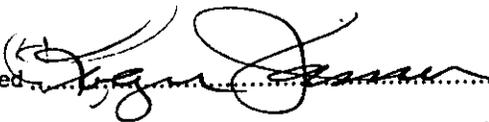
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John J. Welsh

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 

Licensed Embalmer No. 5010

P. O. Address Kansas City, Mo.

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.