

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001323

FILED VS. FEB. 8 1960 142

Primary Registration District No. 0056 Registrar's No. 10

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Goldsberry</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u> c. CITY OR TOWN <u>Mountain View</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Francis</u> Last <u>Gibbons</u>			4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carhender</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (City and state or country) <u>Harrisburg, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Elijah Gibbons</u>		13b. MOTHER'S MAIDEN NAME <u>Wallace</u>		14. NAME OF HUSBAND OR WIFE <u>Grace E. Gibbons</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 <u>Grace E. Gibbons Mtn. View, Mo. Rt.</u>			
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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) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>5 YEARS</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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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 _____ a.m. _____ p.m. Month, Day, Year _____					

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
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21. I attended the deceased from 12-29-59 to 1-26-60 and last saw him alive on 1-26-60
 Death occurred at 1:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. Jeffrey M.D.</u> (Degree or title)	22b. ADDRESS <u>Mtn - View, Mo</u>	22c. DATE SIGNED <u>1-30-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/29/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arroll Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Arroll, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address Ma Va

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.