

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

=60-001566

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>6 MONTHS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSP</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5320 EUCLID AVE.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>J. B. GIBBS</b>				4. DATE OF DEATH Month Day Year <b>JAN 6, 1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7 5 1917</b>	9. AGE (last birthday) <b>42 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASSISTANT PLANT MGR. VANDE KAMP BAKERY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RECTOR ARKANSAS</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>LYNN GIBBS</b>			13b. MOTHER'S MAIDEN NAME <b>Charlie Taylor</b>			14. NAME OF HUSBAND OR WIFE <b>NADYNE GIBBS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WW 11</b>		16. SOCIAL SECURITY NO. <b>411-12-4244</b>		17. INFORMANT Address <b>MRS. J. B. GIBBS 5320 EUCLID</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>		
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)						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		
19. WAS AUTOPSY PERFORMED? YES <input 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 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
21. I attended the deceased from <u>12/15/59</u> to <u>1/6/60</u> and last saw her/him alive on <u>1/6/60</u> Death occurred at <u>1:40 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Leo F. Cooper M.D.</i>				22b. ADDRESS <b>1220 E. 31st Kc Mo</b>			22c. DATE SIGNED <b>1-7-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>1 8 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NORTH HOLLYWOOD CEM</b>		23d. LOCATION (City, town, or county) <b>LOS ANGELES CALIF.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K.C.MO.</b>				25. DATE RECD. BY LOCAL REG. <b>1-7-60</b>		26. REGISTRAR'S SIGNATURE <i>new Marshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Leo F. Cooper

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.