

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005860

Dr. Thomas

FILED VS FEB 29 1960 2000

Registrar's No. 223

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 4 YRS.	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 924 N. MARION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 924 N. MARION Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARK Middle GIBBARD Last GIBBARD			4. DATE OF DEATH Month FEB. Day 21 Year 1960		
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 11/13/55	9. AGE (last birthday) 4	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GENE GIBBARD	13b. MOTHER'S MAIDEN NAME JOELLEN FALK	14. NAME OF HUSBAND OR WIFE X
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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) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT ROBERT FALK, SPRINGFIELD 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) Pneumonia acute		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Severe neurologically impaired child	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) hypertensive edema, cerebral palsy, Extreme difficulty to swallow		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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 SPRINGFIELD, MO.	COUNTY GREENE	STATE MISSOURI
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21. I attended the deceased from **4-16-59** to **2-21-60** and last saw ^{her} _{him} alive on **2-17-60**
Death occurred at **6:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David L. Thomason M.D.	22b. ADDRESS 1630 N. Jefferson	22c. DATE SIGNED 2-23-60
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23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/23/60	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
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24. FUNERAL DIRECTOR H.H. LOHMEYER, SPRINGFIELD, MO.	25. DATE RECD. BY LOGAL REG. 2-25-60	26. REGISTRAR'S SIGNATURE Effie G. Melton
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. McCann*

Licensed Embalmer No. 2727

P. O. Address *Spokane*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.