

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-019026

Dr. Glenn FILED VS MAY 23 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 589

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in 1b <u>46 YRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u> c. CITY OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>810 E. STANFORD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>GIBSON</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/9/14</u>	9. AGE (last birthday) <u>46</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>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>JOHN K. GIBSON</u>			13b. MOTHER'S MAIDEN NAME <u>EVELYN MALAMPHY</u>			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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>500-09-7843</u>		17. INFORMANT Address <u>JOHN K. GIBSON, SPRINGFIELD, MO.</u>				
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>Coronary heart disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						clinical INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
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 _____ 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>5-15-60</u> to <u>5-19-60</u> and last saw him alive on <u>5-18-60</u> Death occurred at <u>7 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Elmer M. Percell M.D.</u>				22b. ADDRESS <u>Springfield Mo</u>			22c. DATE SIGNED <u>5-20-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER FUNERAL HOME</u> <u>SPRINGFIELD, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>5-20-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u> <i>Em</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 1 1960

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 Cecil Taylor

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.