

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032220

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7347**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
JOHN K GIBBS			JULY	23	1960
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Male	White		12/6/1886	73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Retired		Church Janitor		Patton, Missouri, U.S.A.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Jim Gibbs		Amanda Capeheart		Joana Wheeler Gibbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address
No			None		Unknown Mrs. Joana Gibbs, Box 37, Marquand, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) GENERALIZED INFECTION		FEW DAYS
DUE TO (b) CHRONIC LYMPHOCYTTIC LEUKEMIA		YEARS
DUE TO (c) 204. OF		

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.
INTERTROCHANTERIC FRACTURE OF RIGHT HIP		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
? a.m. p.m.	7/9/60 Home		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
	Marquand	Missouri	Missouri

21. I attended the deceased from MAY 18, 1960 to JULY 23, 1960 and last saw her 3:30 A.M. and last saw him JULY 23, 1960 alive on JULY 23, 1960
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<i>C. O. Vermillion, M.D.</i>	BARNES HOSPITAL	7/23/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	7/23/60	Local	Marquand, Missouri.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Albert H. Hoppe, Inc., 4700 Washington Blvd.,	JUL 23 1960	Earl Smith M.D.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

H.T.

JATHR 1966

MS AUG 22 1966 SA

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 Elmo R. Sadler

Licensed Embalmer No. 4077
P. O. Address St Louis

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.