MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17739

1. PLACE OF DEATH
County Livingston
Township Sampsel
City ..... (No. ..... St. ..... Ward)

Registration District No. 962
Primary Registration District No. 5673

File No. .....
Registered No. 6

2. FULL NAME Leona R Gibson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Samuel C Gibson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 26. 98

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
29	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jackson Township
(STATE OR COUNTRY) Livingston Co Mo

PARENTS

10. NAME OF FATHER Lewis P Ott
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Mary Donohue
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Livingston Co Mo

14. INFORMANT Samuel C Gibson
(Address) Sampsel Mo

15. FILED 5-26, 1928 W L White M
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1928

17. I HEREBY CERTIFY, That I attended deceased from May 17 1928, to May 19 1928 that I last saw her alive on May 19 1928, and that death occurred, on the date stated above, at 9.35 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Appendicitis
121B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 117B
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) A. G. Minnick, M. D
May 21, 1928 (Address) Lock Springs Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lock Springs Mo
DATE OF BURIAL: May 20, 1928

20. UNDERTAKER: Jas D Gordon
ADDRESS: Chillicothe Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.