

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

Do not use this space.

FEB 25 1929
5232

1. PLACE OF DEATH

County Washington
Township Boston
City..... (No.....)

Registration District No. 887
Primary Registration District No. 6179

File No.....
Registered No. 1240.....
St. Ward.....

2. FULL NAME

Sarah Ellen 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. da. 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)

unmarried

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

John Gibson

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

1-25-1883

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
45	11	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Bonne Terre Mo.

10. NAME OF FATHER

William Sullins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Sarah Brewster

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Shannon Co. Mo.

14.

INFORMANT John Gibson
(Address) Potosi, Mo.

15.

FILED 1/18, 1929 Jos. L. Thurman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 16 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1929 **to** Jan. 16 1929 **that I last saw h. or alive on** Jan. 16 1929 **and that death occurred, on the date stated above, at** 4:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
1317

CONTRIBUTORY (SECONDARY)

129a

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. F. Thurman, M. D.
1-18, 1929 (Address) Potosi, 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

New Diggins, Mo.

DATE OF BURIAL

1-19 1929

20. UNDERTAKER

Boyerison

ADDRESS

Potosi, 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.

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