

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

Do not use this space.

10975
~~10925~~

1. PLACE OF DEATH

County Cackson Registration District No. _____
 Township Rain Priority Registration District No. _____
 City Kennett, Mo. (No. Westley Hospital) St. _____ Ward _____

File No. _____
 Registered No. 1486

2. FULL NAME

(a) Residence. No. Alexander, Mo. 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 Male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 8 0 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Federal Agent
 (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) Montana

10. NAME OF FATHER William Gibbons

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

12. MAIDEN NAME OF MOTHER Lida Hagger

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

14. INFORMANT (Address) Dora May Gibbons Alexander, Mo.

15. FILED 26, 1929 M. M. Karbone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-25-1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 23, 1929 to Mar 25, 1929 that I last saw h. live on Mar 25, 1929 and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Perforated
perforated
 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Perforated gas bladder
 (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. T. Mackey M. D.

(Address) Laurel, 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 DATE OF BURIAL

Keokuk Iowa 3/26 1929

20. UNDERTAKER ADDRESS

O V Mast 1915 E 15

FEB 18 1933

J. F. MACKEY
OFFICE SUITE
LATHROP BUILDING

KANSAS CITY, MO..

May 20, 1929.

To whom it may concern:

This man fell over in a restaurant while eating. He was taken to the hospital and two days later I opened him up and found a perforated gall-bladder. The cause is unknown.

Respectfully,

J. F. Mackey

S-10975

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township W. City Primary Registration District No. 1002 Registered No. 1486
 City W. City (No.) St. Ward

2. FULL NAME

William Francis Gibbons

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m | w | m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 3/26 59 W. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1929

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Perforated Gall Bladder
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Perforated Gall Bladder
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-10975