

Registration District No. 553

Primary Registration District No. 5754

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Rural, Somerset Tph.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Near, Mercer Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mercer
(c) City or town Rural Mercer, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME James T. Gibson 125
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 25
year 1940 hour 6 minute 15 P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Gibson 6. (c) Age of husband or wife if alive, years December 5, 1855
7. Birth date of deceased. (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 15, 1940 to July 25, 1940
that I last saw him alive on July 9, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Cardiac failure Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>7</u>	<u>30</u>	hr. _____ min. <u>1</u>

Due to Senile Debilitation

9. Birthplace Tenn. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business Henry Gibson
12. Name not known
18. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Cynthia Broyles
15. Birthplace not known (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant H. H. Gibson
(b) Address Trenton, Missouri
17. (a) Burial (b) Date thereof 7/27, 1940
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation South Lineville, Mo.
18. (a) Signature of funeral director D. J. Brumley
(b) Address Lineville, Iowa.
19. (a) July 26, 1940 (b) J. P. Davis
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Dr. A. Martin M.D. or other 3
Address Mercer, Mo. Date signed July 27

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5

RECEIVED

District Health Officer No. 11,

District File Number. 840-1295

Date Filed AUG 14 1940

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.....

Ames L. Greenlee L.E.# 3967

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Ames L. Greenlee

Licensed Embalmer No. 873

P. O. Address Lincolnton, Iowa.

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **25739**

Registration District No. **583**

Primary Registration District No. **2754**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Mercer**
(b) City or town **Somerset, T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **James T. Gibson**
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w**
6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **84** Months **7** Days **20** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure due to myocarditis chronic** Duration _____

Due to ~~_____~~

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **D. K. Martin** (M. D. or other) **DO**
Address **Mercer mo** Date signed **Sept 14**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1940

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25739

Registration District No. 533

Primary Registration District No. 3754

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Merced
 (b) City or town Homersick Twp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME James T. Gibson

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>7</u>	<u>20</u>	_____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

20. DATE OF DEATH Month July day 25
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
 that I last saw him _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.
 Immediate cause of death Cardiac failure Duration _____

Due to Mitral Stenosis 10 yrs.

Due to _____

Other condition Senile Debilitation
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work _____
(Specify type of place)
 Means of injury _____

23. Signature Dr. A. H. Martin (Other) _____
 Address Merced, Mo. Date signed Dec 27 1940

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD