

DEPARTMENT OF HEALTH MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF THE VITALS NOV 20 1940  
 STANDARD CERTIFICATE OF DEATH

35377

Registration District No. 313 322

Primary Registration District No. 5 447

State File No. \_\_\_\_\_

Registrar's No. 23

1. PLACE OF DEATH

(a) County GREENE Fair Haven Mo  
 (b) City or town Springfield Rural Jackson 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miles  
 (c) City or town Eldon  
 (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

J. J. McRibbin

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 Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 29 - 1860

(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 10

If less than one day

hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Flat Rock, Illinois

(City, town, or county)

(State or foreign country)

10. Usual occupation Doctor - Retired

11. Industry or business Deceased

12. Name John M. Ribben

13. Birthplace unknown

(City, town, or county)

(State or foreign country)

14. Maiden name Margaret J. Smith

15. Birthplace unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant Mrs. Mary Gregory

(b) Address 111 East W. Kirby, Melcher, Mo.

17. (a) Removal (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph, Missouri

18. (a) Signature of funeral director Eden M. Ray

(b) Address Eldon Mo

19. (a) 9 - 1940 (b) Allan Barnes

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th day November  
 year 1940 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him in bed on November 9th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death heart failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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? in Public Place

While at work? no (Specify type of place) (e) Means of injury heart failure

23. Signature Jas. B. Bayon, P.P. acting coroner

Address 116224, Do. Rebburn Date signed 11-9-40

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

see affidavit # 279 in mine file

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

Registration District No. 322

Primary Registration District No. 5447

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Jackson 710  
(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)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John James McKibbin  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH Nov 7 1940 month 7 day 7  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

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)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

8. AGE: Years 79 Months 5 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Nov 11 41 (b) Allan Barnes  
(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? \_\_\_\_\_

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

23. Signature J. B. Pearson, M.D. (M. D. or other)

Address Springfield Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

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

