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7-39
K23159
AFO

REG 12 1940
Registration District No. 80

Primary Registration District No. 3-120

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Caston R.F.D. 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Tremont, township
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Caston R.F.D. 1
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
0
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME William Watt 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 Married

6. (b) Name of husband or wife Mr. Sara Gibson 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March 31 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name William Watt Gibson

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

14. Maiden name Lucy Ellen Culhnan

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

16. (a) Informant Mrs. Sara Gibson

(b) Address Caston R.F.D. 1

17. (a) Burial (b) Date thereof 11/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director T. A. Sullivan
(b) Address Gowery, Mo

19. (a) Nov. 6 - 1940 (b) Mrs. Lucy Powell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5
year 1940 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan - 10th 1936 to Nov - 5th 1940
that I last saw him alive on Nov 5th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Chronic Arthritis of 27 yrs duration

Due to _____

Other conditions (Include pregnancy within 3 months of death) u2

Major findings: Of operations _____

Of autopsy _____

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? (11)

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

23. Signature S. D. Reynolds (M. D. or other) !

Address Plattburg Mo Date signed 11-6-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DEC 18 1958

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: *H. A. Sullivan*

Licensed Embalmer No. *1738*

P. O. Address *Gower, Mo*

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.