

S. No. 1-18-6
5-27-39
MAR 11 1941

FD MAR 11 1941

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 123

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
214 W. Mrs. Vernon
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mos
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME JONATHAN RAGAIN GIBSON

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Clara Gibson 6. (c) Age of husband or wife if alive approx 70 years

7. Birth date of deceased November 11 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business None

12. Name Jonathan R. Gibson

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

14. Maiden name Wiley Evans

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

16. (a) Informant C. A. Gibson

(b) Address 1603 College Springfield, Mo.

17. (a) Removal (b) Date thereof Feb 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrison Arkansas

18. (a) Signature of funeral director Christison Funeral Home While at work _____ (Specify type of place)
(b) Address Harrison Arkansas (e) Means of injury —
(c) 2-12-41 (b) W. E. Handley MD Signature W. E. Handley MD (M. D. or other)
(Date received local registrar) (Registrar's signature) Address 227 E. Olive Date signed _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Lawrence
(If outside city or town limits, write "RURAL")
(d) Street No. 109 Church St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10
year 1941 hour 5 minute A.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 Deceased died of the brain as per statement by Dr. C. E. Fuller, but no doctor attending at the time. Duration _____

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? _____

(e) Means of injury —

Signature W. E. Handley MD (M. D. or other)
Address 227 E. Olive Date signed _____

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

39
2
6

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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 69767
Registrar's No. 123

Registration District No. 318 Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County Barren
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
214 W. Mt. Vernon St. (According to our record)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution by Coroner
G. H. Boehm. (Specify whether)

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 Jonathan Regain Gibson
(b) If veteran, name war _____
(c) Social Security No. _____

20. DATE OF DEATH month Feb day 10
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 _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced div
(b) Name of husband or wife _____
(c) Age of husband or wife if alive _____ years

Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 78 Months 2 Days 29 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) 6/17/41 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

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 W. E. Handley MD (M. D. or other)

Address 227 E Olive Springfield Mo Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

