

FILED MAY 8 1942

Registration District No. 237

Primary Registration District No. 4144

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Dade Center Twsp.
(b) City or town Greenfield, Mo.
(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 Many years. years, months or days

3. (a) PRINT FULL NAME George Wash. Gipson.

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

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

6. (b) Name of husband or wife Wife Josie Haley n Gipson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 11 1965
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>77</u>	<u>6</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Day laborer.

11. Industry or business _____

MOTHER FATHER { 12. Name Abraham Gipson
13. Birthplace Greenfield, Mo.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Lydia
15. Birthplace Greenfield, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Josie Gipson
(b) Address Greenfield, Mo.

17. (a) Burial (b) Date thereof April, 23, 42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenfield Cem.

18. (a) Signature of funeral director J. W. Ward
(b) Address Greenfield, Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade
(c) City or town Greenfield,
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1942 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from June 22, 1941, to April 20, 1942
that I last saw him alive on April 16, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration April 1942

Due to Atherosclerosis General 1935

Due to _____

Other conditions hypertension 1938
(Include pregnancy within _____ months of death)

Major findings: Of operations _____
Of autopsy 131b
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 J. D. Shannon (M. D. or other) DO
Address Greenfield, Mo Date signed 4/23/42

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death.

RECEIVED

District Health Officer No. 6,

District File Number 542-634

Date Filed MAY 6 1942

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 J. W. Ward

Licensed Embalmer No. 2882

P. O. Address Greenfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

State File No. 141 56

Registration District No. 231

Primary Registration District No. 5323

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shade
(b) City or town Greenfield
(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 _____ (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 George W. Gijson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 26
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19____;
that I saw him/her die on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 11 1896
(Month) (Day) (Year)

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

8. AGE: Years 77 Months 6 Days 11 If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry of business _____

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) Apr 25 '42 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

Duration _____
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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

