DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

20831

State File No.

Registration District No. 13057 Primary Registration District No. 5189 Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Cape

(b) City or town: rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Cape 16 0

(c) City or town: rural 0

(If outside city or town limits, write "RURAL")

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: IRA Richard Gibbons

3. (b) If veteran, name war: 1st world war

3. (c) Social Security No. 498-10-0147

4. Sex: male

5. Color or race: white

6. (a) ~~Single, widowed~~, married, divorced: married

6. (b) Name of husband or wife: May

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

7. Birth date of deceased: July (Month) 7 (Day) 1896 (Year)

8. AGE: Years 46 Months 9 Days 28 If less than one day hr. min.

9. Birthplace: Harrisburg Saline Co Ill (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer Saline Co Ill

11. Industry or business:

FATHER 12. Name: Thomas Austin Gibbons

13. Birthplace: Harrisburg Saline Ill (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Maud Robin Simpson

15. Birthplace: Harrisburg Saline Co Ill (City, town, or county) (State or foreign country)

16. (a) Informant: Earl Gibbons

(b) Address: Delta Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 7 - 42 (Month) (Day) (Year)

(c) Place: burial or cremation: Kenyon

18. (a) Signature of funeral director: Geo Wilson

(b) Address: Jackson Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 6 day year 1942 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 2 - 42, 1942, to July 6, 1942, that I last saw him alive on July 5, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
cerebral hemorrhage	6 mo
Due to high blood pressure	
Due to hardening of arteries	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none

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): none

(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? (e) Means of injury

23. Signature: W W Davault (M. D. or other) Md

Address: Ellsinville Mo Date signed July 6 42

140
142

1135

(Licensed Embalmer's Statement on Reverse Side)

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20831

Registration District No. 130 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Cape Girardeau Co

(b) City or town rural Welch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(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 mo (b) County Cape

(c) City or town rural, Welch
(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 Ira Richards Gibbons

3. (b) If veteran, name war World War

3. (c) Social Security No. 498-100147

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife May

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

7. Birth date of deceased Sept (Month) 7 (Day) 1898 (Year)

8. AGE:

Years	Months	Days	If less than one day
46	9	27	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) 1/9-42 (Date received local registrar) (b) A. H. Marks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1942 hour minute M.

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

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W W Dewault (M. D. or other) MD
Address Allenville Mo Date signed Sept 19 '42

SUPPLEMENTARY