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S. No. 2
M-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2306-7
Registrar's No. 2306-7E

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

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Registration District No. 317

Primary Registration District No. 6067

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 819 DAYS
(Specify whether years, months or days)

In this community 819 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4120^e ENRIGHT 7
(If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME ANNA GEORGIA GIBSON

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

4. Sex 3 FEMALE 5. Color or race COLORED

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

6. (b) Name of husband or wife CAL GIBSON 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased MAY 13, 1911
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

32 4 27 hr. min.

9. Birthplace HIGHPOINT N.C. 1
(City, town, or county) (State or foreign country)

10. Usual occupation /

11. Industry or business /

MOTHER FATHER { 12. Name RANDALL INGRAM

13. Birthplace ? N.C. 1
(City, town, or county) (State or foreign country)

14. Maiden name MARTHA ALLEN

15. Birthplace 3 N.C. 1
(City, town, or county) (State or foreign country)

16. (a) Informant PATIENT

(b) Address ROBERT KOCH HOSPITAL

17. (a) Ship. (b) Date thereof Oct. 14, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greensboro, N. C.

18. (a) Signature of funeral director Dement & Son

(b) Address 2626-31 Cole St.

19. (a) 10-13-43 (b) C. V. TR... [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 9 year 1943 hour 6 minute 9 A.M.

21. I hereby certify that I attended the deceased from AUGUST 12, 1941 to OCTOBER 9, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY T.B.C. Duration 2 YEARS?

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 13 ft

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? _____
(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 Bernard Friedman M.D. (M. D. or other) M.D.
Address Koch Hos, Koch, Mo. Date signed 10-9-43

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Dr. H.K.

OCT 18 1943

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..... *William Claude Gordon*
Licensed Embalmer No..... *3489*
P. O. Address..... *415 75 Aldine*

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.