S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9806

Registrar's No. 1580

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: Lake Side Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 days (Specify whether
In this community 21 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 9520 Blue Ridge
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Annie Dora Gibson

3. (b) If veteran, name war NO

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Jan. (Month) 12 (Day) 1866 (Year)

8. AGE: Years 78 Months 2 Days 28 If less than one day hr. min.

9. Birthplace unknown (City, town, or county) Ohio 1 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name William Stroud
13. Birthplace Unknown (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant H. T. Gibson (son)
(b) Address Adrian, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (Month) (Day) (Year)
(c) Place: burial or cremation Galt, Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn Kansas City Mo.

19. (a) 4-10-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 10 year 1944 hour 4 minute 40 a.m.

21. I hereby certify that I attended the deceased from Dec 1940 to 4-9- 1944 that I last saw her alive on 4-9- 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cardiac Failure | 6 days |
| Toxemia | 3 wks. |
| Due to Intestinal Obstruction | 4 wks. |
| Due to Adhesions | 4 yrs. |
| Other conditions Lobar Pneumonia (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy 108

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 G. F. Pease (M. D. or other) VD

Address 3100 Troost Date signed 4-10-44

(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 Ralph W. Runnels

Licensed Embalmer No. 3860

P. O. Address Kansas City, 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.**