

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED DEC 21 1945 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40108

State File No. _____
Registrar's No. 5019

Registration District No. 149 Primary Registration District No. 1002

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

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: Research Hospt. 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette 54
 (c) City or town Odessa
(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 Anna Nora Gibson
 3. (b) If veteran, name war no 3. (c) Social Security No. none
 4. Sex Female 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife C.L. Gibson 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased Jan. 8, 1878
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 30
 year 1945 hour 4 minute 00 A.M.
 21. I hereby certify that I attended the deceased from Nov. 10, 1945, to Nov. 30, 1945.
 that I last saw h. er alive on Nov 9 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>10</u>	<u>22</u>	hr. _____ min.

Immediate cause of death coronary atherosclerosis
 Duration _____
 Due to _____
 Due to _____
 Other conditions 94 or
(Include pregnancy within 3 months of death)

9. Birthplace Odessa, Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation At Home

11. Industry or business.
 MOTHER FATHER {
 12. Name M.M. Robinson
 13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
 14. Maiden name Mattie Gibbs
 15. Birthplace Virginia
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant C.L. Gibson
 (b) Address Odessa, Mo.
 17. (a) Removal (b) Date thereof Nov. 30, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Odessa, Mo.
Husman-Sparks
 18. (a) Signature of funeral director _____
 (b) Address Odessa, Mo.
 19. (a) 12-6-45 (b) S. S. Holms
(Date received local registrar) (Registrar's signature)

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. C. Campbell (M. D. or other) _____
 Address 314 E. 17th St. Odessa, Mo. Date signed 1/4/46

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 James T. Heisman
Licensed Embalmer No. 2591
P. O. Address Olean, N.Y.

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.