

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30253
Registrar's No. 3890

FILED SEP 25 1946

Registration District No. 199 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: General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 hrs. 20 min.
(Specify whether years, months or days)

In this community 13 years
(years, months or days)

3. (a) PRINT FULL NAME John D. Gibbs

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 5. Color or race wh

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

7. Birth date of deceased July 14-1932
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>14</u>	<u>1</u>	<u>28</u>	hr. min.

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

10. Usual occupation School boy

11. Industry or business

12. Name Charles E. Gibbs

13. Birthplace Glasgow, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Kathryn Cuddy

15. Birthplace Glasgow, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Charles E. Gibbs

(b) Address 3601 Troost

17. (a) burial (b) Date thereof 9-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director J. S. Walton

(b) Address R. C. Mo

19. (a) 9-13-46 (b) Margeline Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 3601 Troost
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1946 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from Sept. 11 19 46 to Sept. 12 19 46
that I last saw him alive on Sept. 12 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Poliomyelitis

Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations 36

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)

(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 Wm W. Hail (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 9-13-46

Dr. Anderson

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. S. Walker*.....

Licensed Embalmer No. *2744*.....

P. O. Address *K. C. 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.