

FILED MAR 21 1947

978

Registration District No. 449

Primary Registration District No. 1002

Registrar's No. _____

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: Lakeside Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community since 1928 (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 46

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4514 Olive, 8
(If rural, give location)

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

If yes, name country X

3. (a) PRINT FULL NAME Miss Inez Faye Gibson

3. (b) If veteran, name war no. 3. (c) Social Security No. 491-20-7506

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased July 26 1911
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1947 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from Feb. 26
1947 to March 2 1947
that I last saw her alive on Feb 5 March 2 1947
and that death occurred on the date and hour stated above.

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

35 7 26 hr. min.

Immediate cause of death Lobar Pneumonia Duration 3 days

Due to _____

Due to _____

9. Birthplace Hardin, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Inspector

Other conditions Renal Insufficiency months
(Include pregnancy within 3 months of death)

Major findings: 108 PHYSICIAN _____

Of operations _____

Of autopsy Lobar Pneumonia
Renal Insufficiency

Underline the cause to which death should be charged statistically.

11. Industry or business Burlington Mfg. Co.

12. Name Ira C. Gibson 0

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

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 2

14. Maiden name Faye Auten

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

16. (a) Informant Mrs. Raymond McCoy

(b) Address 4514 Olive, Kansas City, Mo.

17. (a) burial (b) Date thereof 3-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 3-4-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature R. A. Murren (M. D. or other) 00

Address 1120 Chambers Bldg. Date signed 3-3-47

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

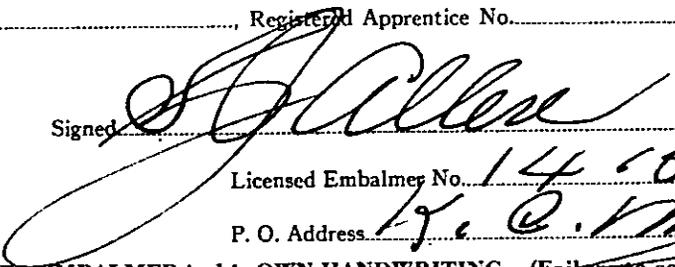
MOTHER FATHER

MAR 25 1947

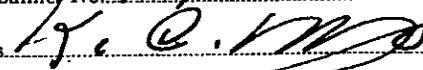
STATEMENT BY LICENSED EMBALMER

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 .....

Licensed Embalmer No. 1456.....

P. O. Address .....

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.