

FILED APR 23 1947
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1624

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

(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)

In this community 26 yrs
years, months or days)

3. (a) PRINT FULL NAME Edward Gibbs

3. (b) If veteran, name war none

3. (c) Social Security No. 496-16-4290

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Daisy Gibbs

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

7. Birth date of deceased Mar 7 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>7</u>	<u>01</u>	<u>1</u> hr, _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Wm Gibbs

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

14. Maiden name Rogge

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

16. (a) Informant Clyde T. Gibbs

(b) Address 3615 Euclid

17. (a) Burial (b) Date thereof April 11 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs C.R. Foster

(b) Address 918 Broadway

19. (a) 4-9-47 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2800 E. 10 St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1947 hour 6 minute 25 A.M.

21. I hereby certify that I attended the deceased from April 3 1947 to April 8 1947.
That I last saw him alive on April 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Generalized arteriosclerosis with arteriosclerotic heart disease and terminal bronchopneumonia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 93d

Major findings:
Of operations _____

Of autopsy See above

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 0

23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 4-8-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Jerry A. Mirro....., Registered Apprentice No. *437*
working under my personal supervision.

Signed.....
C. H. Wise

Licensed Embalmer No. *25-70*

P. O. Address.....
15 @ 9th

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.