

FILED AUG 14 1947 3

Registration District No. _____ Primary Registration District No. **H 14 J** Registrar's No. **11**

1. PLACE OF DEATH:
 (a) County **COOPER**
 (b) City or town **PRAXIE HOME**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **75 yr** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **COOPER 27**
 (c) City or town **PRAXIE HOME MO 0**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) FULL NAME **WYRA E. GIBBERTH**
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **4** year **1947** hour **6** minute **0**
21. I hereby certify that I attended the deceased from **2** to **1947** to **Aug 4**, 19**47**
 that I last saw him **live on Aug 31** and that death occurred on the date and hour stated above.
 Immediate cause of death **Coronary Heart Disease**
 Due to **upper arm**

4. SEX **FEMALE** **5. Color or race** **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased _____ (Month) **10** (Day) **1860** (Year)

8. AGE:			If less than one day
Years	Months	Days	
86	8	24	hr. _____ min.

9. Birthplace _____ (City, town, or county) **MISSOURI** (State or foreign country)

10. Usual occupation **RETIRED**

11. Industry or business _____
12. Name **JAMES W. BOSWELL**
13. Birthplace _____ (City, town, or county) **MISSOURI** (State or foreign country)
14. Maiden name **NANCY JONES**
15. Birthplace _____ (City, town, or county) **MISSOURI** (State or foreign country)

16. (a) Informant **Hugh J. Silbreach**
(b) Address **Praxie Home mo.**
17. (a) REMOVAL (b) Date thereof **8-6-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **BOONVILLE CEM.**

18. (a) Signature of funeral director **C. Albert Hornbeck**
(b) Address **Praxie Home mo**
19. (a) 8-6-47 (b) **A.L. Meredith**
 (Date received local registrar) (Registrar's signature)

Duration _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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 **A.R. Meredith** (M. D. or other) _____
Address **Praxie Home mo** _____

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

MOTHER FATHER

JUNE 1949

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 *C. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prairie Home 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Aug*Registration District No. *33*Primary Registration District No. *443*Registrar's No. *119*

1. PLACE OF DEATH:

(a) County *Cooper*
(b) City or town *Prairie Home*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

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

(d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days)3. (a) PRINT
FULL NAME *Myra E. Gilbreath*

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Wed*

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

7. Birth date of deceased *7 in 10*
(Month) (Day) (Year)8. AGE: Years *86* Months Days If less than one day hr. min.9. Birthplace (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *Aug 6* (b) *M. D. Meredith*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug*
year *1947* hour minute M.21. I hereby certify that I attended the deceased from *7* to *10* 19*47*that I last saw him *alive* on *10* 19*47*

and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

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