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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 5 1947

Registration District No. 147

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 24185

Registrar's No. 2991

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 919 Bennington /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: no (Specify whether)

In this community: 25 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson 48

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

(d) Street No.: 919 Bennington Ave., 8
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME: MARGARET MINERVA GIBSON

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Fem /

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Married /

6. (b) Name of husband or wife: Eugene Gibson

6. (c) Age of husband or wife if alive: 75 years

7. Birth date of deceased: 7/24/1871 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	11	20	hr. min.

9. Birthplace: Oak Grove (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation: Housewife

11. Industry or business: --

FATHER
12. Name: James Borland 9
13. Birthplace: Unk. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary E. Darrow
15. Birthplace: Carthage, Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant: Lillian Gibson

(b) Address: 919 Bennington Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/16/47 (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove, Mo.

18. (a) Signature of funeral director: John P. Sheil

(b) Address: K. C. Mo.

19. (a) 7-15-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14 year 1947 hour 9 minute 17 A.M.

21. I hereby certify that I attended the deceased from Jan-10-1947 ~~July 14~~ 1947 to July 14 1947 that I last saw h. alive on July 13 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Haemorrhage	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: none

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: 0

23. Signature: Paul A. G. Johnson (M. D. or other)

Address: 3011 A. Independence Ave. Date signed: 7/15/47

(Licensed Embalmer's Statement on Reverse Side)

Dr. Paul A. G. Johnson
3011-A Indep. Ave.,
After 1 P M

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 John P. Steil

Licensed Embalmer No. 3625

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.