

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 15 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7275

1. PLACE OF DEATH:

(a) County 1113 N 14th St

(b) City or town St. Louis MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home 1  
(If not in hospital or institution, write street number or location)

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

In this community 24 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis MO  
(If outside city or town limits, write "RURAL")

(d) Street No. 1113 N 14th St  
(If rural, give location)

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

3. (a) PRINT FULL NAME KATTIE GIBSON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2nd year 1947 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 8-1-47 to 8-2-47 that I last saw her alive on 8-1-47 and that death occurred on the date and hour stated above.

4. Sex female

5. Color or race Negro

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 2 (Month) 5 (Day) 1898 (Year)

Immediate cause of death, acute cardiac congestive

Duration \_\_\_\_\_

8. AGE: Years 54 Months 5 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

12. Name Henry Lipscomb

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

14. Maiden name Emma

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

16. (a) Informant Alfred McClelland

(b) Address 1113 N 14th St

17. (a) Burial (b) Date thereof 8. 7. 47.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Wood

18. (a) Signature of funeral director Davis & Brown

(b) Address 1405 Biddle St

19. (a) AUG 5 1947 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

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 J. A. Cadene Hill (M. D. or other) \_\_\_\_\_  
Address 923 N 16th St Date signed 8-4-47

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

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**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.

*Emb. Cert. to be filed*

Signed.....

Licensed Embalmer No.....

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.**