

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5922**
1086

FILED MAR 13 1953

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY c. LENGTH OF STAY (in this place) 60 yrs. d. FULL NAME OF HOSPITAL OR INSTITUTION BENTON MANOR				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY d. STREET ADDRESS (If rural, give location) 535 MARSH 305th			
3. NAME OF DECEASED (Type or Print) a. (First) DELIA b. (Middle) _____ c. (Last) GIBSON			4. DATE OF DEATH (Month) (Day) (Year) FEB. - 18 - 1953				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH AUG. 4 - 1864		9. AGE (In years last birthday) 88 if UNDER 1 YEAR: Days _____ if UNDER 1 MRS. Hours _____ Mts. _____		
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME CRONKITE			13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE CHARLES E. GIBSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME CHARLES E. GIBSON JR.			ADDRESS WEST NEWTON MASS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 12 yrs. 38 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Influenza				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			21. ACCIDENT SUICIDE HOMICIDE (Specify) _____		
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 1942 to Feb. 18, 1953, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Herman Shablin (Degree or title) D.O.				23b. ADDRESS 3705 St. John		23c. DATE SIGNED 2-20-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB. 23 - 1953	24c. NAME OF CEMETERY OR CREMATORY MT. MORIAH		24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI		
DATE REC'D BY LOCAL REG. 2-21-53		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.H. Blackburn & Son Inc.			

K.C. Mo.

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed W.C. Rinne

Licensed Embalmer No. 4879

P. O. Address K.C. Miami

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.