No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42393

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10998

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS Mo
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN ST. LOUIS
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 14 5854 NEOSHO 2149 0

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) KATHERINE c. (Last) GIBBONS

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30 1954

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH Nov. 27 1889
9. AGE (In years last birthday) 65 If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and State or Foreign Country) IRELAND 4
12. CITIZEN OF WHAT COUNTRY? U-S-A

13a. FATHER'S NAME PATRICK LOWRY
13b. MOTHER'S MAIDEN NAME MARY DONELON
14. NAME OF HUSBAND ~~OR WIFE~~ AUGUSTIN S. GIBBONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME AUGUSTIN GIBBONS ADDRESS 5854 NEOSHO

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremic Poisoning — INTERVAL BETWEEN ONSET AND DEATH 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension CVR Syndrome yes
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 442X

22. *I hereby certify that I attended the deceased from* 11/25, 1954, *to* 11/30, 1954, *that I last saw the deceased alive on* 11/30, 1954, *and that death occurred at* 2 12 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] M.D.
23b. ADDRESS 4075 S Grand
23c. DATE SIGNED 12/2/54

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE DEC. 3 1954
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.
24d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

DATE REC'D BY LOCAL REG. DEC 2 1954
REGISTRAR'S SIGNATURE J Carl Smith MD MDB
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Gravois

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leo J. Budde

Licensed Embalmer No. 39

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.