

FILED APR 28 1955

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3285**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		c. CITY OR TOWN St. Louis STREET ADDRESS (If rural, give location) 5442 Lindenwood Ave. 2190	

3. NAME OF DECEASED (Type or Print) JOHN	a. (First)	b. (Middle) A.	c. (Last) GIBSON	4. DATE OF DEATH (Month) (Day) (Year) Apr. 10 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 21, 1881	9. AGE (In years last birthday) 73 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) Salesman-Franklin		10b. KIND OF BUSINESS OR INDUSTRY Real Estate Co.		11. BIRTHPLACE (City and State or Foreign Country) Mo.
13a. FATHER'S NAME James Robert Gibson		13b. MOTHER'S MAIDEN NAME Rebecca Green		12. CITIZEN OF WHAT COUNTRY? U S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. 489-10-2968	17. INFORMANT'S SIGNATURE OR NAME Ollie E. Gibson		ADDRESS 5442 Lindenwood Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis			
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from **4-6-1955**, to **4-10-1955**, that I last saw the deceased alive on **4-9-1955**, and that death occurred at **3:30P** m., from the causes and on the date stated above.

23a. SIGNATURE R. R. Ruppel	(Degree or title) D	23b. ADDRESS 5203 Clipperton	23c. DATE SIGNED 4-12-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 13, 1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. APR 12 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	ADDRESS 4228 S. Kingshighway Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *William R. White*.....

Licensed Embalmer No. *4228*

P. O. Address *4228th Ave*

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

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