

FILED FEB 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

7391

Registration District No. 366

Primary Registration District No. 6241

Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Washington</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Rural Britton Twp.</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Rural</i> 1100 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>New Paton</i> Length of stay in 1b <i>20 yrs.</i>		d. STREET ADDRESS (If outside, give location) <i>New Paton</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Samuel Gibson</i> First Middle Last		4. DATE OF DEATH Month <i>Feb.</i> Day <i>25</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 23 1874</i>
9. AGE (In years last birthday) <i>82</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>mining</i>	
11. BIRTHPLACE (City and state or country) <i>St. Francis Co. Mo. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Gibson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Sago</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Wyman Gibson</i> Address <i>Crystal City, Mo.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation from food.</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Amputation stump both legs</i> <i>Blindness</i> DUE TO (c) <i>9369</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>47</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3</i>		
20c. TIME OF INJURY Hour <i></i> Month <i></i> Day <i></i> Year <i></i> a. m. <i></i> p. m. <i></i>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>Apr - 2 - 1955</i> to <i>Feb. 25 - 1957</i> and last saw <i>him</i> alive on <i>Dec. 12 - 1956</i> . Death occurred at <i>7:30 P. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Joseph L. Therman - M.D.</i> (Degree or title)	22b. ADDRESS <i>121 E. 4th - Polton, Mo.</i>	22c. DATE SIGNED <i>2-26-1957</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>2-28-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Higgins Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Washington Co. Mo.</i>
24. FUNERAL DIRECTOR <i>Mr. Luther Sparks Paton, Mo.</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>2/26/57</i>	26. REGISTRAR'S SIGNATURE <i>Herbert Rudolf</i>

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embolmer's Statement on Reverse Side)

RECEIVED

FEB 26 1957.

WASH. COUNTY HEALTH DEPT.

File No. _____

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 *Murphy L. Spahr*
Licensed Embalmer No. *13*
P. O. Address *St. Paul*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.