

FILED JUL 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 021811
State File No. _____

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 3041 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Chariton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon	c. LENGTH OF STAY (In this place) 2 Mo.	c. CITY OR TOWN Rural Bee Branch Twp	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Samaritan Hospital		e. STREET ADDRESS (If rural, give location) R.R. New Cambria	

3. NAME OF DECEASED (Type or Print) Cyrus		a. (First) L.	b. (Middle) Gipson	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 6 20 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-9-1876		9. AGE (In years last birthday) 81	10. MONTHS 0	11. DAYS 11	12. HOURS 11	13. MIN. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and State or Foreign Country) Chariton Co. Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Columbus Gipson		13b. MOTHER'S MAIDEN NAME Mary Catherine Gates		14. NAME OF HUSBAND OR WIFE Bessie Noble Gipson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Bessie Gipson		ADDRESS New Cambria, Mo.	

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) <u>Hemiplegia, left</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Hypertension</u>		<u>1 yr.</u>	
				DUE TO (c) <u>Myocarditis</u>		<u>2 yrs.</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>Pyelitis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/>	
						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?	

22. I hereby certify that I attended the deceased from 28 April, 1957, to 20 June, 1957, that I last saw the deceased alive on 19 June, 1957, and that death occurred at 10:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. E. Eagleston M.D.</u>		(Degree or title)		23b. ADDRESS <u>Macon, Missouri</u>		23c. DATE SIGNED <u>27 June 57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE <u>6-23-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>		24d. LOCATION (City, town, or county) (State) <u>Macon, Missouri</u>	

DATE REC'D BY LOCAL REG. <u>6/24/57</u>		REGISTRAR'S SIGNATURE <u>Cuth Mcneely</u>		FEDERAL DIRECTOR'S SIGNATURE <u>R. Lester Bram</u>		ADDRESS <u>Macon, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

County
Date Filed 7.2.57

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 *R. Lester Bram*

Licensed Embalmer No. 44

P. O. Address *Macon*

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.