THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 15 1957

STATE FILE NUMBER 24557

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3527

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General #2 — Length of stay in Hospital 10 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2307 Vine — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Josephine [redacted] Middle Lost Gibson

4. DATE OF DEATH: Month July Day 24 Year 1957

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH Sept. 3, 1890

9. AGE (In years last birthday) 66 — 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 country) Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Lutishia Graham Address 2407 Vine

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition and dehydration. (m.m.e.)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 2865
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 July 21, 1957 to July 24, 1957 and last saw her/him alive on July 24, 1957
Death occurred at 10:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. R. Peterson M.D. (Degree or title)

22b. ADDRESS 600 East 22nd Street

22c. DATE SIGNED 7-26-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 7-29-57

23c. NAME OF CEMETERY OR CREMATORY Lincoln

23d. LOCATION (City, town, or county) (State) K.C. Mo

24. FUNERAL DIRECTOR Burgess & Jones ADDRESS 18th & Park

25. DATE RECD. BY LOCAL REG. 7-27-57

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. R. Peterson

KP 2

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 442

P. O. Address 2300 E

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