

Health,
& Welfare
Public
Service

FILED VS AUG 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-030414

STATE FILE NUMBER
Registration No. 7528

Registration District No. Primary Registration District No.

5. 300
1-57
8
19
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2035 Franklin	

3. NAME OF DECEASED (Type or print) First Bennie Middle David Last Gibson			4. DATE OF DEATH Month 8 Day 10 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1909	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Pickens Miss	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Andy Gibson	13b. MOTHER'S MAIDEN NAME Kelly Green	14. NAME OF HUSBAND OR WIFE Dead
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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. -	17. INFORMANT H.C. Gibson Address 4112 Delmar Blvd
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardiorenal Disease	
	DUE TO (c) 442x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mucocele of Appendix		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	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
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21. I attended the deceased from 8-8-59 to 8-10-59 and last saw her/him alive on 8-10-59 Death occurred at 5:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) W. B. Basselle M.D.	22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 8-11-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Pickens, Miss.	23b. DATE 8-15-59	23c. NAME OF CEMETERY OR CREMATORY Pickens Miss	23d. LOCATION (City, town, or county) (State) Pickens Miss
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24. FUNERAL DIRECTOR Miss Love ADDRESS 2930 Dickens	25. DATE RECD. BY LOCAL REG. AUG 13 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy W. Darrist*

Licensed Embalmer No. *4523*
P. O. Address *4251 Wash*

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.