

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043934
6259 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6259

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>66 YEARS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S HOSPITAL</u>						d. STREET ADDRESS <u>5208 HIGHLAND AVENUE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>ROBERT</u> Last <u>GIBSON</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>15</u> Year <u>1963</u>			5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/17/1897</u>		9. AGE (last birthday) <u>66</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PROCTOR & GAMBLE MANUFACTURING CO.</u>		11. BIRTHPLACE (City and state or country) <u>KANSAS CITY KANSAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROBERT A. GIBSON</u>			13b. MOTHER'S MAIDEN NAME <u>MARY HARRISON</u>			14. NAME OF HUSBAND OR WIFE <u>MRS. ADA B. GIBSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u>						16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. ADA B. GIBSON 5208 HIGHLAND AVE. KANSAS CITY MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>PERFORATED DUODENAL ULCER</u>			DUE TO (c) <u>PERFORATED DUODENAL ULCER</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CARCINOMA of LARYNX with Generalized Metastasis</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)							
20c. TIME OF INJURY Hour <u>8:20</u> a.m. <u>A.</u> Month, Day, Year <u>11/15/63</u>		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 <u>1956</u> to <u>11/15/63</u> and last saw her/him alive on <u>11/15/63</u> Death occurred at <u>8:20 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE <u>Leo F. Cooper MD</u> (Degree or title)		22b. ADDRESS <u>4620 Jc Nichols Pkwy</u>		22c. DATE SIGNED <u>11/16/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV. 18, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY - KANSAS CITY MISSOURI</u>		23d. LOCATION (City, town, or county) (State) <u>MISSOURI</u>		24. FUNERAL DIRECTOR <u>DW NEWCOMER'S SONS KANSAS CITY, MO</u>			
25. DATE RECD. BY LOCAL REG. <u>11-18-63</u>		26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>									

Dr. Leo F. Cooper
427 Plaza Parkway Bldg - 4620 J. C. Medical Parkway
9:00-1:00

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

Robert Ray

Licensed Embalmer No.

4182

P. O. Address

K. C. Mo.

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.