

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Buchanan

Township _____ or _____

Village _____ or _____

City St. Joseph

Registration District No. 85

File No. 17000

Primary Registration District No. 1001

Registered No. 423

(NO. State Hospital # 2)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME James Gordon

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Widower WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____, 1846
(Month) (Day) (Year)

AGE 65 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Iron Fitter
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Mo. S.S.

PARENTS NAME OF FATHER Unk. BIRTHPLACE OF FATHER (City or town, State or foreign country) N. Car.
MAIDEN NAME OF MOTHER Unk. BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. Car.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. P. Mills M.D.

(ADDRESS) St. Joseph Mo.

Filed May 20 1911 W. B. Kelling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 20, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 6th, 1908, to May 20th, 1911, that I last saw him alive on May 20th, 1911,

and that death occurred, on the date stated above, at 10:20 AM. The CAUSE OF DEATH* was as follows:

Old Senile Dementia
16 1/2 (Duration) 3 yrs. _____ mos. _____ ds.

Contributory Insanity (SECONDARY) (Duration) 3 yrs. _____ mos. _____ ds.

(Signed) H. P. Mills M. D. May 20th, 1911 (Address) St. Joseph Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted If not at place of death? _____

Former or usual residence St. Joseph Mo.

PLACE OF BURIAL OR REMOVAL Coaston Mo DATE OF BURIAL May 21 1911

ADDRESS H. C. Sidney 215 No 10

