JAN 17 1928

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

Do not use this space.

35832

1. PLACE OF DEATH

County: Adair — Registration District No.: 45006 — File No.:

Township: Salt River — Primary Registration District No.: — Registered No.: 172

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Mrs Sarah Gordon

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: C. W. Gordon

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 1" 1841

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
86	11	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

PARENTS

10. NAME OF FATHER: Samuel Taylor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known

14. INFORMANT: Harry Gordon
(Address): La Plata, Mo.

15. FILED: 12 30 1927 — A W Parrish, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12/29" 1927

17. I HEREBY CERTIFY, That I attended deceased from May ....., 1927, to Dec 28, 1927, that I last saw her alive on Nov 17, 1927, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infirmities of old age.

162

..... (duration) — yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY): 164

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

12/30, 1927 (Signed) H M Humphrey, M. D
(Address) Brashear Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Brashear Cemetery — DATE OF BURIAL: 12/31 1927

20. UNDERTAKER: F. R. Easley — ADDRESS: Brashear.

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.