

JAN 22 1929

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

Do not use this space.

39666

1. PLACE OF DEATH

County Callaway
Township Fulton
City Fulton (No. _____)

Registration District No. 104

Primary Registration District No. 3008

File No. _____

Registered No. 238

2. FULL NAME

Woodford Gordon Kansas City Mo

(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 6 yrs. — mos. — ds. How long in U.S., if of foreign birth? _____ yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word)

Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day	hrs.	min.
<u>68</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hotel Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT Medical Certificate
(Address) _____

15.

FILE NO. Dec 25 28 REGISTRAR R. N. Crew

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

12/25/28

17.

I HEREBY CERTIFY, That I attended deceased from Sept 5 1928 to Dec 25 1928 and I last saw him alive on Dec 25 1928, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Syphilis

CONTRIBUTORY (SECONDARY)

Syphilis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Don't know

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) E. E. Fox M. D.
, 19 (Address) State Hospital

*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

Columbia Mo Dec 27 1928

20. UNDERTAKER

Oh Bell Fulton Mo

ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

