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

Do not use this space.

8740

1. PLACE OF DEATH

County: Jackson — Registration District No. 399

Township: Kaw — Primary Registration District No. 1002

City: Kansas City (No. ..... General Hospital ..... St. ..... Ward)

File No. .....

Registered No. 1118

2. FULL NAME: Thomas Gordon

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

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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 8. 1882

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerical 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) Pa

PARENTS

10. NAME OF FATHER: Anthony Gordon

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

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT: Coroner's Record
(Address) Kansas City, Mo

15. FILED 3/13 19 30 M. M. Graves
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 13, 30 19

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Homicide
175 B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Skull fractured in fight ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

3/13 19 30 (Signed) Stanley M. Hale, M. D.
(Address) Deputy Coroner

*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: Sagertown Ga — DATE OF BURIAL 3/14 1930

20. UNDERTAKER: R. V. Lindsey & Sons, Inc. — ADDRESS Kans. City

City