

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.

NOV 21 1930

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

Do not use this space.

35296

1. PLACE OF DEATH

County Barry
Township Cass
City (No. _____) _____ St. _____ Ward _____

Registration District No. 31
Primary Registration District No. 2042B

File No. _____
Registered No. 24

2. FULL NAME

Regena Marie 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29, 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
6 6 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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) Oklahoma

10. NAME OF FATHER Ben Gordon

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

12. MAIDEN NAME OF MOTHER Thelma Young

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

14. INFORMANT Ben Gordon
(Address) Daddy No. P. 7 D

15. FILED 11-10-1930 Mattie Blauenshik
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Nov 2, 1930 that I last saw h. e. r. alive on Nov 2, 1930, and that death occurred, on the date stated above, at 3 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

CONTRIBUTORY (SECONDARY) NO
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) NO
(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? no

WHAT TEST CONFIRMED DIAGNOSIS Physical findings, culture, laboratory
(Signed) C. W. Poor, M. D.

, 19 _____ (Address) Wheaton, 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 New Church Cem. DATE OF BURIAL Nov. 5 1930

20. UNDERTAKER J. W. Anderson ADDRESS Wheaton

