

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 701

Township.....

Primary Registration District No. 1013

City St. Louis (No. City Hospital #2)

File No. 7575

Registered No. 1931

2. FULL NAME

Gertrude Sandon Landon

(a) Residence. No. 813 Benton St. 26 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs.; mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 - 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 7 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

10. NAME OF FATHER Peter Dixon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) ?

14. INFORMANT G. S. Landon
(Address) 813 Benton St

15. FILED 1931 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-9 1931

17. No Physician in attendance I HEREBY CERTIFY. That I attended deceased from 19....., to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries (Concussion of Brain - Fractured Pelvis) struck by auto in St. Louis. Duration (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 210 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. J. [Signature] M.D.

2/10 1931 (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 Washington Park DATE OF BURIAL Feb 14 1931

20. UNDERTAKER J. M. [Signature] ADDRESS 3517

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

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.

