

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9467

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2950**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Carroll City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Louis A. Gordon

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years about 55 Months _____ Days _____ If less than one day _____ hr _____ min.

9. Birthplace Unknown
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Unknown

13. Birthplace "
(City, town, or county) (State or foreign country)

14. Maiden name "

15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Engel - P.D.

(b) Address 5811 Royal

17. (a) _____ (b) Date thereof March 1940
(Burial, cremation, or reburial) (Month) (Day) (Year)

(c) Place: burial or reburial St. Louis

18. (a) Signature of informant [Signature]

(b) Address 5811 Royal

19. (a) MAR 29 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 10
year 1940 hour 3 minute 55 P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Hepatitis

Due to _____

Due to Edema of Brain

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 5

23. Signature [Signature] (M.D. or other) _____

Address [Signature] (Date signed)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____; Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.