

Registration District No. 89Primary Registration District No. 5131

1. PLACE OF DEATH:

(a) County Butler
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 months
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME Evin Gordin8. (b) If veteran, name war _____ 8. (c) Social Security No. none4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed6. (b) Name of husband or wife any Gordin 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Oct 14, 1854
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
86 11 23 hr. min.9. Birthplace Ohio
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business _____

12. Name Giles Gordin13. Birthplace Ohio
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature J. G. Gordin(b) Address Fisk, Mo.17. (a) Removal (b) Date thereof 10-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Cooter, Mo.18. (a) Signature of funeral director M. S. Shamm(b) Address Fisk, Missouri19. (a) 10-6-41 (b) Belle Kinnear
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12
 (c) City or town Rural Ash Hill Twp
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 6
year _____ hour _____ minute _____ M.21. I hereby certify that I attended the deceased from Oct 5
Oct 5 1941 to Oct 5 1941
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic myocarditis
Campylobacter 2 days

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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)

28. Signature Alfred B. Bous (M. D. or other)
Poplar Bluff Date signed 11 Oct 6-41
Address _____

RECEIVED

District Health Office No. 2,

District File Number 2041-14

Date Filed 10/20/41

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

Wallace W. Fitch

Licensed Embalmer No. 5859

P. O. Address Poplar Bluff

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

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