

S. No. 2
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. 5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9620

State File No.

FILED APR 25 1949

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 1352

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community 50 Years years, months or days)

3. (a) PRINT FULL NAME Mrs. Mary Gordon

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John N. Gordon 6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased December 28 1858
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 27 If less than one day
.....hr.min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name James H. Preston
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Mary Elizabeth Carroll
15. Birthplace Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant H. G. Gordon
(b) Address Grandview, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 8, 1948
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director D. N. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 4-6-42 (Date received local registrar) (b) M. M. Crowe
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Grandview (If outside city or town limits, write "RURAL.")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th
year 1942 hour 6 minute 45 A. M.

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

that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death encephalomalacia.

Due to Hypertension
Cerebral arteriosclerosis
Due to Chronic pyelonephritis
Other conditions (Include pregnancy within 3 months of death) 83c

Major findings: Of operations

Of autopsy as above.

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) (e) Means of injury ↓

23. Signature John Lapp (M. D. or other) M.D.
Address Professor Bldg. Date signed 4-5-48

(Licensed Embalmer's Statement of Reverse) Dr. D. J. Stump Research Hospital

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

48
93

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 Emily Colborn

Licensed Embalmer No. 3506

P. O. Address. KC mo

APR 1 1951

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, fact should be so stated above.