No. 5-43
7-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7037

FILED FEB 25 1946

Registration District No. 517

Primary Registration District No. 3070

Registrar's No. 399

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

5989

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
367 Sidney Ave Webster Groves
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

(c) City or town Webster Groves 19 7
(If outside city or town limits, write "RURAL")

(d) Street No. 367 Sidney 4
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Frank C Gordon

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Sept (Month) 27 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	4	16	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Retired

11. Industry or business Frisco Rail Road

FATHER
12. Name Caldwell Gordon
13. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Henrietta
15. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Mrs. Golda M. Yadon

(b) Address 367 Sidney, Webster Groves 19 Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/14/46. (Month) (Day) (Year)

(c) Place: burial or cremation Crocker, Mo.

18. (a) Signature of funeral director MITTELBERG FUNERAL HOME
WEBSTER GROVES, MO.

(b) Address .....

19. (a) 2-16-46 (Date received local registrar) (b) E G M Garran MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 2 day 13
year ..... hour 12 minute noon M.

21. I hereby certify that I attended the deceased from any, 1945, to Feb. 13, 1946
that I last saw him alive on Feb. 12, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Auricular Fibrillation	2 wks.
Due to	
Due to	
Other conditions Metastatic carcinoma (Include pregnancy within 3 months of death)	—
Major findings: Following fractolectomy	
Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? ..... (Specify type of place)

(e) While at work? ..... (e) Means of injury 0

23. Signature C. J. Vollmer (M. D. or other) MD

Address 53 W. Big Bend Date signed 2/14/46

(Licensed Embalmer's Statement on Reverse Side)

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 John M. Meyer

Licensed Embalmer No. 3385

P. O. Address 340 W. Adams Kirkwood 22, Mo

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.

No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7037

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webstre Groves
(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 ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Frank C. Gordon

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Sept (Month) 27 (Day) 1874 (Year)

8. AGE: Years 71 Months 4 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb/ day 13
year 1946 hour ..... minute ..... 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	Duration
Metastatic Carcinoma	
Due to following prostatectomy	
Cancer of prostate	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

51B

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

23. Signature R. J. Vollmer MD (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

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

5988

7037