

FILED JUL-9 1949
#63244

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21390

State File No. 5642

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 2624a Louisiana Ave.,					
3. NAME OF DECEASED (Type or Print) a. (First) GORDON			b. (Middle)		c. (Last) MCNEIL		4. DATE OF DEATH (Month) (Day) (Year) May 3rd, 1949		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Feb. 19th		9. AGE (In years as birthday) all - 65 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown Kentucky			12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Frank Gordon			13b. MOTHER'S MAIDEN NAME Martha Johnson			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME M.A. Renard ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma Stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) HP MO					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 151K					
22. I hereby certify that I attended the deceased from 4/10/49, 19 , to 5/3/49 , 19, that I last saw the deceased alive on 5/3/49 , 19, and that death occurred at 2:00 PM. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) J.E. Adams M.D.				23b. ADDRESS 1515 Lafayette Ave.,			23c. DATE SIGNED 5/3/49		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JUN 30 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. JUN 30 1949		REGISTRAR'S SIGNATURE J.B. Faraster			25. FUNERAL DIRECTOR'S SIGNATURE Howland Mortuary Service ADDRESS 4104 Manchester Ave				

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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, fact should be so stated above.