

FILED AUG 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. R. K. Knapp  
State File No. 28084

BIRTH NO. 41803-49 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 6668

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Springfield</b>	c. LENGTH OF STAY (in this place township) <b>15 Min.</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>1031 N. Warren</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lloyd</b>	b. (Middle) <b>- - -</b>	c. (Last) <b>Gordon</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 27, 1949</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED, SEPARATED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>July 27, 1949</b>
9. AGE (In years last birthday) <b>15</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	IF UNDER 12 HRS. Hours <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Springfield, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Almis A. Gordon</b>		13b. MOTHER'S MAIDEN NAME <b>Wyona West</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Almis Gordon Springfield, Mo.</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.	<p align="center"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Atelectasis</b></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Prematurity</b></p> <p>DUE TO (c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>		INTERVAL BETWEEN ONSET AND DEATH  <b>76.25</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
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?	
22. I hereby certify that I attended the deceased from <b>27 July, 1949</b> , to <b>27 July, 1949</b> , that I last saw the deceased alive on <b>27 July, 1949</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above.			
23. SIGNATURE (Degree or title) <b>Samuel E. Knapp, D.M.D.</b>		23b. ADDRESS <b>1630 N Jefferson</b>	23c. DATE SIGNED <b>28 July 49</b>
24a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7/28/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bellview Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Near Springfield, Mo.</b>
DATE REC'D BY LOCAL OFFICE <b>7-30-49</b>	REGISTRAR'S SIGNATURE <b>N.S. Hurdley M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H.H. Lohmeyer Springfield, Mo.</b>	

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No.....

This body was not embalmed.

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.