

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35059**

FILED OCT 19 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1095

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>80 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>305 Alabama St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Eliza</u>	b. (Middle) <u>Jane</u>	c. (Last) <u>Gordon</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 8, 1953</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>August 3, 1859</u>	9. AGE (in years last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Quincy, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Chapman</u>	13b. MOTHER'S MAIDEN NAME <u>Emalie Morris</u>	14. NAME OF HUSBAND OR WIFE <u>Jack</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John T. Walsh</u>	ADDRESS <u>305 Alabama, St. Joseph, Mo</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>traumatic shock fall</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Fract R Hip - R shoulder</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chr. Valvular Heart Dis</u>		<u>10 yrs</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>E9030</u> <u>20</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Buchanan Mo.</u>
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct 7 1953 7:45 AM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell on Bath Room floor</u>
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22. I hereby certify that I attended the deceased from 10/6, 1953, to 10/8, 1953, that I last saw the deceased alive on 10/6, 1953, and that death occurred at 10:10a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J R [Signature]</u>	(Degree or title) _____	23b. ADDRESS <u>134 Ill. Ave, City</u>	23c. DATE SIGNED <u>10/8/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>10/10/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Oct 15, 1953</u>	REGISTRAR'S SIGNATURE <u>Lothar W. Allison</u>	483	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton-Bowman Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 10th St. Joseph*

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.