

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9629**
2149

FILED MAR 31 1955

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 No. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 12-days		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital		e. STREET ADDRESS (If rural, give location) 24 3831a Iowa Ave. 2249	

3. NAME OF DECEASED (Type or Print)	a. (First) Michael	b. (Middle) P.	c. (Last) Gordon	4. DATE OF DEATH (Month) (Day) (Year) March 6, 1955
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5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Sept. 12, 1869	9. AGE (In years) (Month) (Day) (Year) 85 5 34	IF UNDER 1 YEAR (Hours) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watchman-Calvary Cemetery	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Michael Gordon	13b. MOTHER'S MAIDEN NAME Catherine Mullen	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Miss Katherine Kiley	ADDRESS 3831a Iowa Ave.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural Hematoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Trauma DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home	21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo. 000
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 25, 1955 a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell	E9040
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22. I hereby certify that I attended the deceased from **Feb 25, 1955**, to **Mar 6, 1955**, that I last saw the deceased alive on **Mar 6, 1955**, and that death occurred at **11:15 a.m.** from the causes and on the date stated above. **21**

23a. SIGNATURE (Degree or title) Edward Kneille	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 3/7/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE March 9, 1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAR 8 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE J. Donnelly	ADDRESS 840 Lindell Blvd.
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m 9/8. (Licensed Embalmer's Statement on Reverse Side)

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

