

FILED MAY 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016906

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1235

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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy Twnshp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis 12</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>37 Chas. the 1st.</u>		Length of stay in lb <u>18 Days</u>	d. STREET ADDRESS (If outside, give location) <u>121 5540 Delmar Blvd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MISS LULA</u> Middle <u>(NMN)</u> Last <u>GORDON</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1958</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1877</u>		9. AGE (In years last birthday) <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Campaign Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YWCA Nat'l Office</u>	11. BIRTHPLACE (City and state or country) <u>Carlyle, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>J. Taylor Gordon</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Frances Challis</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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. <u>None</u>		17. INFORMANT Address <u>William A. Gordon 5540 Delmar Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic vascular disease many years.</u>					
DUE TO (c) <u>331X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>diabetes mellitus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan. 1-58</u> , to <u>May 4-58</u> and last saw her alive on <u>May 4-58</u> Death occurred at <u>11 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Francis R. Ritchie M.D.</u>			22b. ADDRESS <u>5733 Watson Ave.</u>		22c. DATE SIGNED <u>4-5-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>5/5/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis co. Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons, 6175 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>5-5-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Bomke M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Frances Ritchie
5233 Waterman
Fo 7-5071
Call between 12:30-1

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
Signature of Student Embalmer

Signed *Joe E. McCulloch*

Licensed Embalmer No. *2464*
P. O. Address *6175 Delmar*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.