

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007146
STATE FILE NUMBER
2 1286

FILED FEB 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar 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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp.		d. STREET ADDRESS (If outside, give location) 2433 O'Fallon Apt. 206	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Verlinda Middle Gordon Last Gordon			4. DATE OF DEATH Month Feb. Day 3 Year 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1888
9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Greenville, Mississippi	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Smith Burnley	13b. MOTHER'S MAIDEN NAME Elizabeth Freeman	14. NAME OF HUSBAND OR WIFE Robert Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr. Marion Tillard 5724 Theodosia Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip. DUE TO (b) E904.0 DUE TO (c) 21 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suffered in fall at 2433 O'Fallon Street, Apartment #207 about 5:30 p.m. on February 1st, 1959.			
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Exact nature of injury in PART I or PART II of item 18.) fell out of window		
20c. TIME OF INJURY Hour 5:30 Month, Day, Year 2 1 59 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.) Home		20f. CITY, TOWN, OR LOCATION St. Louis Mo	
20g. COUNTY Mo		20h. STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 9:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. J. B.		22b. ADDRESS 1300 Ch...	
22c. DATE SIGNED 2/3/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/9/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR G. Wade Granberry 4202 Finney Ave.		25. DATE RECD. BY LOCAL REG. FEB 5 '59	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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
Signature of Student Embalmer

Signed *Edward A. Flynn*

Licensed Embalmer No. **4444**

P. O. Address **4202 Finney Ave.**

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.