

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028228  
STATE FILE NUMBER

FILED VS. SEP 14 1959 042

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 915

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>5 years</b>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b>				d. STREET ADDRESS <b>2021 Faraon St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Meyer</b> Middle _____ Last <b>Gordon</b>				4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 27, 1888</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Grocer &amp; Delicatessen Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Samuel Gordon</b>			13b. MOTHER'S MAIDEN NAME <b>Sadie Mendell</b>			14. NAME OF HUSBAND OR WIFE <b>Bertha Gordon</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>unknown</b>		17. INFORMANT Address <b>Mrs. Jack Zurow St. Joseph, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of urinary bladder</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.		Month, Day, Year _____					
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 <b>8/31/59</b> to <b>9/5/59</b> and last saw him alive on <b>9/5/59</b> Death occurred at <b>10:15 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>H. L. Warren M.D.</b>				22b. ADDRESS <b>902 Edmund, St Joseph, Mo.</b>		22c. DATE SIGNED <b>9/8/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Sept. 7, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>R'nai Yaakov Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Meierhoffer &amp; F. L. ... St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Sept. 9 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

DOCUMENT

H.L. Warren, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 17 1955

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stine J. Chumley

Licensed Embalmer No. 4679

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.