

RI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

FILED VS AUG 27 1959

59-030424

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7616**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 50 Yrs.		c. CITY OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2030 Sidney		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Ira Last Gordon				4. DATE OF DEATH Month 8 Day 15 Year 59			
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-28-81	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles Gordon			13b. MOTHER'S MAIDEN NAME Mattie Hammond		14. NAME OF HUSBAND OR WIFE Nancy Gordon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Yes(Unk(17. INFORMANT Address Nancy Gordon 2030A Sidney			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis Pneumonia bilateral DUE TO (b) Bronchogenic Carcinoma of Lung DUE TO (c) 162.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Aut Solventic Heart Disease					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 checked="" type="checkbox"/> NO <input 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 8-2-59 to 8-15-59 and last saw her/him alive on 8-14-59 Death occurred at 345-A on the date stated above and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Carl J. Allen M.D. (Degree or title)				22b. ADDRESS 18th Highway		22c. DATE SIGNED 8-17-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-18-59	23c. NAME OF CEMETERY OR CREMATORY Ava Cemetery		23d. LOCATION (City, town, or county) (State) Ava Illinois			
24. FUNERAL DIRECTOR ADDRESS McLaughlin 2301 Lafayette Ave			25. DATE RECD. BY LOCAL REG. AUG 17 '59		26. REGISTRAR'S SIGNATURE Heal Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR
11-18-1911

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 A. G. Farris

Licensed Embalmer No. 3384
P. O. Address A. G. Farris

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.