

URIAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 8 9 6

FILED VS. DEC. 23 1959 55

Primary Registration District No. 5875 Registrar's No. 32

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY OREGON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY OREGON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN THOMASVILLE		Length of stay in 1b 6 yrs.		c. CITY OR TOWN THOMASVILLE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR THOMAS GORDON				4. DATE OF DEATH Month Day Year 12-11-1959			
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months 9 Days 27	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER AND STOCK DEALER			10b. KIND OF BUSINESS OR INDUSTRY CEDAR GROVE, MO.		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME T. D. GORDON			13b. MOTHER'S MAIDEN NAME MARY THOMPSON		14. NAME OF HUSBAND OR WIFE AGNES FRANKS, THOMASVILLE, MO		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address THOMASVILLE, MO		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertension Essential PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (b) Previous CVA @ Arteriosclerosis generalized 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						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
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.) Generalized			
20c. TIME OF INJURY Hour _____ s.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 June 1953 12-11-59 and last saw him alive on 11-29-58 Death occurred at 1:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Jack P. Wales, M.D. (Degree or Title)				22b. ADDRESS West Plains, Mo		22c. DATE SIGNED 12-15-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE 12-13-59		23c. NAME OF CEMETERY OR CREMATORY WOODSIDE		23d. LOCATION (City, town, or county) (State) THOMASVILLE, MO	
24. FUNERAL DIRECTOR ROBERTSONS, WEST PLAINS, MO				25. DATE RECD. BY LOCAL REG. Dec 18 1959		26. REGISTRAR'S SIGNATURE Mrs WC Johnson	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 17 1960

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 *D. K. Roberts*

Licensed Embalmer No. 3437

P. O. Address West Fla

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.