

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6421

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.**

(**Lutheran Hospital**)

File No.....
Registered No. **1622**
St. Ward)

2. FULL NAME *Wayton Gordon*

(a) Residence. No. **3006 Cherokee** St., **16** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
Male

4. COLOR OR RACE
White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 17 - 1889**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	45	5	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Salesman**

(b) General nature of industry, business, or establishment in which employed (or employer) **House hold goods**

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) **Indiana**

10. NAME OF FATHER **John Gordon**

11. BIRTHPLACE OF FATHER (CITY OR TOWN), (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **"**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN), (STATE OR COUNTRY) **"**

14. INFORMANT **Carl D. Gordon**
(Address) **3006 Cherokee St.**

15. FILED **FEB 16 1927** **Maryl Starckoff**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 15 - 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Feb 13**, 19**27**, to **Feb 15**, 19**27** that I last saw him alive on **Feb 15**, 19**27**, and that death occurred, on the date stated above, at **9:40a** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute gangrenous appendicitis
17 1/2 (duration) yrs. mos. **4** da.
CONTRIBUTORY Diffuse general peritonitis
(SECONDARY) (duration) yrs. mos. **2** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

1 DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Feb 13, 1927**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **surgical operation**

(Signed) **Robert G. Shultz** M. D.
2/15, 19**27**, (Address) **514 Michigan Bldg**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Indianapolis Ind.** DATE OF BURIAL **Feb. 17 - 1927**

20. UNDERTAKER **Ziegenhein Bros. 2623 Cherokee St.** ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

