

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

Do not use this space.

15395

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township St. Joseph, Primary Registration District No. 1001
 City St. Joseph, (No. Noyes-Baptist Hospital) St. _____ Ward _____

File No. _____
 Registered No. 617

2. FULL NAME Sallie Eleanor Gordon,

(a) Residence. No. 1602 South 20th. St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 18, 1852

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	77	9	5	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. At Home,
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Monroe County,
 (STATE OR COUNTRY) West Virginia,

10. NAME OF FATHER Adam Mann,

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

12. MAIDEN NAME OF MOTHER Elizabeth Barker,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
 (STATE OR COUNTRY) West Virginia,

INFORMANT Mrs. P. P. Crawford
 (Address) 1501 South 18th Street.

15. FILED 1930 19 John G. Tibb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1 1929, to May 23 1930 that I last saw her alive on May 22 1930, and that death occurred, on the date stated above, at 4:15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial nephritis with out edema -

131
57A (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Arthritis Deformans
 (SECONDARY) (duration) 6 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) H. S. Crawford M. D.
5/23, 1930 (Address) St Joseph Mo

*State the DISEASE CAUSING DEATH, or if 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 Mount Mora Cemetery, DATE OF BURIAL May 24, 1930

20. UNDERTAKER Heaton-Bellevue-Burns ADDRESS 319 S. 10 St.
Funeral Home

CAUSE OF DEATH - If plain language may be properly classified. Exact statement of OCCUPATION is very important.

MAILED
1930

