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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16012

Registration District No. 821 Primary Registration District No. 4553 Registrar's No.

1. PLACE OF DEATH:
(a) County ~~[illegible]~~ Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sikeston Genl. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County DeKalb 994
(c) City or town DeKalb 11
(If outside city or town limits, write "RURAL")
(d) Street No. 604 So. 4th St 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? unknown years.

3. (a) PRINT FULL NAME Esther Rose Gordon

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ike Gordon
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
?	65			hr. min.

9. Birthplace Vilna (City, town, or county) Russia (State or foreign country)
10. Usual occupation House wife
11. Industry or business
FATHER
12. Name Fogel
13. Birthplace (City, town, or county) Russia (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) " (State or foreign country)
16. (a) Informant Clark Gordon
(b) Address 604 S 4th St DeKalb, Ill.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-41 (Month) (Day) (Year)
(c) Place: burial or cremation Chicago Ill.
18. (a) Signature of funeral director John Athillon
(b) Address Sikeston Mo.
19. (a) 5-6-1941 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1941 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 2, 1941, to May 2, 1941; that I last saw her alive on May 2, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Shock	
Due to Head Injury & Severe Laceration Scalp	
Due to Automobile accident	✓
Other conditions (Include pregnancy within 3 months of death) None	
Major findings: Of operations None	
Of autopsy None	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 5-2-41 103
(c) Where did injury occur? Gray Ridge (City or town) Stoddard (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 742 Am N.S. Highway 60 (Specify type of place)
While at work? (e) Means of injury Automobile accident

23. Signature A. D. Martin (M. D. or other) M.D.
Address Sikeston, Mo Date signed 5-2-41

(Licensed Embalmer's Statement on Reverse Side)

170 C6
98

4200 W. Roosevelt Rd
& Karlan
Palmer & Lohr Funeral

RECEIVED
District Health Officer N
District File Number 541-5
Date Filed 5/8/4

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 ..... Registered Apprentice No. ..... working under my personal supervision.

Signed John Albritton

Licensed Embalmer No. 2941

P. O. Address Sikeston M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16072

Registration District No. 821 Primary Registration District No. 4553 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ester Rose Gordon
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock 170 C 2

Due to Head injury & severe laceration of salt

Due to auto accident

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Vehicles involved: Auto carrying deceased and another auto.
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) acc
(b) Date of occurrence 5-2-1941
(c) Where did injury occur? Gray Ridge (City or town) (County) (State) Mo
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
N.S. Hgw. # 60
(Specify type of place)
While at work? (e) Means of injury

23. Signature P. D. Martin (M. D. or other) M.D.
Address Sikeston, Mo. Date signed 6/27/41