

Registration District No. 38 Primary Registration District No. 3026

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 606 N 6th St
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Wilkins Gordon
3. (b) If veteran, name war no
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 24th
year 1943 hour 6 minute 11
21. I hereby certify that I attended the deceased from Oct 20 1943
10 to Oct 24 1943
that I last saw him no alive on Oct 24 1943
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 27 1877
(Month) (Day) (Year)

Immediate cause of death Pneumonia
Duration _____

8. AGE: Years 66 Months 2 Days 27
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Includes pregnancy within 3 months of death) _____

9. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)
10. Usual occupation Furrier & Painter

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Charles W. Gordon
13. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Lukins
15. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant James Gordon
(b) Address Columbia mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26-43
(Month) (Day) (Year)
(c) Place: burial or cremation Columbia Cem
18. (a) Signature of funeral director R O. Willis
(b) Address Columbia
19. (a) 10-26-43 (Date received local registrar) (b) Edna H. Barber (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Edna H. Barber (M. D. or other)
Address Columbia Mo Date signed _____

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

MOTHER FATHER

15 11 10

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

Rowley

Licensed Embalmer No.

3183

P. O. Address.....

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **FILED NOV**
Registrar's No. **256**

Registration District No. **28** Primary Registration District No. **3006**

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

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Wm Wilkins Corder
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased aug 27 (Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days _____ Unless than one day _____ min.

9. Birthplace mo (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

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) (Data received local registrar) _____ (b) (Registrar's signature) _____

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month oct day 25 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her on _____, 19____; and that death occurred on the date and hour stated above. Cause of death pneumonia Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J A Cropper (M. D. or other) _____
Address 1117413 Date signed october 25

SUPPLEMENTARY

107

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

34081