

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 24 1945
Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 1075

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 days
(Specify whether years, months or days)
 In this community 25 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1108 Troost
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas Gordon
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 5
 year 1945 hour 6 minute 15 P.M.

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Mabel Gordon
 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased May 18 - 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 17, 1945 to March 5, 1945
 that I last saw him alive on March 5, 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 9 Days 8 If less than one day 17 hr. _____ min. _____

Immediate cause of death Carcinoma of stomach
 Duration _____

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

Due to _____
 Due to _____

10. Usual occupation _____

Other conditions 4/6 hr
(Includes pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN
 Major findings: Of operations _____
 Of autopsy None
 Underline the cause to which death should be charged statistically.

12. Name unknown
 13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name unknown
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mabel Gordon
 (b) Address 1108 Troost

17. (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary KCV

18. (a) Signature of funeral director John C. Ferguson
 (b) Address 12 E. 11th St

19. (a) 3-7-45 (b) H. C. Brown
(Date received local registrar) (Registrar's signature)

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 Clark W. Luby M.D.
 Address Med. Dir. Gen'l Hosp. Date signed 3-8-45

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

10
3
8

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



Licensed Embalmer No. 4773

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.