

FILED MAR 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6412
Registrar's No. 1407

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place) 49	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 22 2301 LaSalle Street	

3. NAME OF DECEASED (Type or Print) Callie Gordon			4. DATE OF DEATH (Month) (Day) (Year) Feb 9 1952		
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5. SEX Female 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1	8. DATE OF BIRTH December 2, 1879	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 7	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Starkville Mississippi		12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Jim Hunter		13b. MOTHER'S MAIDEN NAME Classie Higgins		14. NAME OF HUSBAND OR WIFE Buchanan Gordon	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mamie Bell, 2301 LaSalle St			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Oedema DUE TO (c) Cardiac Hypertrophy				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H3H!

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mamie Bell		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 2/11/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 5	24b. DATE Feb 14-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) Starkville Miss (State)
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DATE REC'D. BY LOCAL REG. FEB 14 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Avenue
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed..... *S J Hatton*

Licensed Embalmer No. *2698*

P. O. Address *2769 Cherokee*

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.