

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

Do not use this space.

**32928**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Kansas Primary Registration District No. 100 Registered No. 4156  
 City Kansas Cit. Mo. No. General Hosp A St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Jordan Clifford  
 (a) Residence No. 1613 E. 10th St. 2 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>21</u>	<u>Yrs</u>			

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Postes  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kansas Cit. Mo.  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER Lew Jordan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) 7  
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Unknown

14. INFORMANT Recard to best  
 (Address) General Hospital NO2

15. FILED 10/13 30 M.M. Croome  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/4/1930

17. I HEREBY CERTIFY, That I attended deceased from 10/1/1930, 1930 to 10/4/1930, 1930, that I last saw him 8:30 PM live on 10/1/30, 1930, and that death occurred, on the date stated above, at 8:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
32 H  
108  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Miliary Tuberculosis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 37 W  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
 (Signed) D.M. Miller M. D.

10/5/1930 (Address) General Hospital NO2

\*State the DISEASE CAUSING DEATH, or in 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 Blue Ridge Lave DATE OF BURIAL 10-13 1930

20. UNDERTAKER H.B. Croome ADDRESS 1820 E 18th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

