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.

OCT 20 1933

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

Do not use this space.

27706

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7597

City St. Louis Mo (No. the Barnard Free Skin and Cancer Hospital 3427 Washington Ward)

2. FULL NAME Esther Jordan

(a) Residence, No. 4247 W St. Ferdinand St., 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Amos Jordan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-21-1892

7. AGE YEARS 41 MONTHS 5 DAYS 6 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laundress

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

FATHER

13. NAME Fred Galloway

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Adeline Robinson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Amos Jordan 4247 W St. Ferdinand Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood DATE 9/3rd 1933

19. UNDERTAKER (ADDRESS) W. C. Gordon Und. Co. 2649-51 Delmar Blvd.

20. FILED SEP -2 1933 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

4

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-27, 1933

22. I HEREBY CERTIFY, That I attended deceased from 8/23, 1933, to 8/27, 1933

I last saw her alive on 8/27, 1933. Death is said to have occurred on the date stated above, at 8 00 p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Intra abdominal hemorrhage caused from removing tumor	8/25/33
139 C	
95A	

54

Other contributory causes of importance:

Cardiac Fibrillation	8/26/33
Fibroid tumor of uterus	

Name of operation Hysterectomy Date of 8/25/33

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury ....., 19....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. Tansey, M. D.

(Address) 3427 Washington Av