

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

Do not use this space.

DEC 20 1937

40075

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Stacy Primary Registration District No. 1002
 City St. Louis City (No. 1710 Euclid)

File No. _____
 Registered No. 353
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1710 Euclid St., _____ 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 Fe 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 19, 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>35</u>	<u>43</u>	<u>10</u>	<u>10</u>	

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

13. NAME James Jones

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

15. MAIDEN NAME Mollie Rush

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

17. INFORMANT (ADDRESS) Louis Jordan
1710 Euclid

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 11/1

19. UNDERTAKER (ADDRESS) Datkins Bros
1729 Lydes

20. FILED Nov. 1, 1937 M. H. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/29 1937

22. I HEREBY CERTIFY, That I attended deceased from 9-6-37 to 10/29/37
 I last saw her alive on 10-29-37 Death is said to have occurred on the date stated above, at 6:45 P.
 The principal cause of death and related causes of importance were as follows:

Chronic interstitial nephritis (Date of onset 13/1)
cerebral apoplexy

Other contributory causes of importance: _____

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

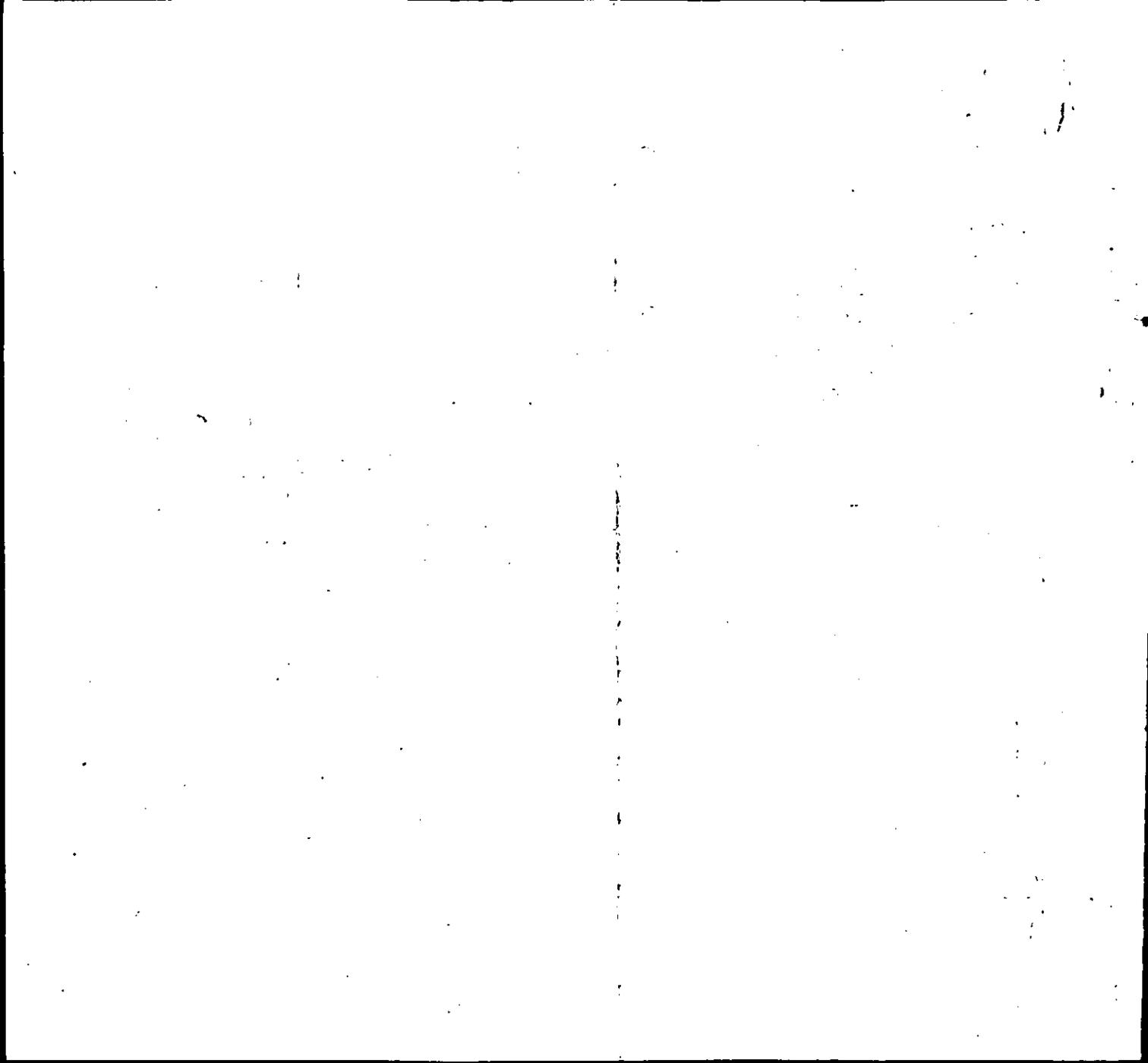
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) G. J. Faught, M. D.
 (Address) 2202 E-18

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.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40075-
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township W. C. Primary Registration District No. 1002 Registered No. 4389
(c) City W. C. (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ella Jordan

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
43 10 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov. 1, 1937 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-29, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

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

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify

(Signed) F. J. Haughey, M. D.

(Address) 2200 E 18th

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Every recurring memorandum 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.

SUPPLEMENTARY

