

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH791
10034910
Do not use this space.

Registered No. 1603

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

D. 14465

2. PRINT FULL NAME

635 Marie Jordan

(a) Residence, No. 2308 Hebert St. 20 (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 7 13

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. hwk
 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) Missouri13. NAME Hiram Hawk14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? UNKNOWN15. MAIDEN NAME Annie Smith16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind17. INFORMANT Hosp. Info M. Kent
(ADDRESS)18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEMETERY DATE FEB 20, 193919. FUNERAL DIRECTOR (NAME) W. L. Goodhart
(ADDRESS) 2228 St. Louis ave20. FILED FEB 19 1939 J. B. Bullock Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/16/39, 1922. I HEREBY CERTIFY That I attended deceased from 1/4/39 to 2/16/39, 19

I last saw her alive on 2/16/39, 19. Death is said to have occurred on the date stated above, at 11.50 p m.
 The principal cause of death and related causes of importance were as follows:

Chronic Tuberculosis
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 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?
 If so, specify

(Signed) W. L. Goodhart, M. D.
 (Address) City Hospital No. 1

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.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

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. 2777

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, above space should be left blank.