

Dr. Stewart

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

32230

Do not use this space.

1. PLACE OF DEATH ^{DECD OCT 10 1939}

(a) County Cole Registration District No. 213
 (b) Township Jefferson Primary Registration District No. 3014 Registered No. 221
 (c) City Jefferson (d) Street No. 320 East Ashley 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William A. Jordan

(a) Residence, No. 320 East Ashley 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

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-23-1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 6 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Shoe Repair
 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) Jefferson City, Mo13. NAME Jordan14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known15. MAIDEN NAME Not Known

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

17. INFORMANT Mrs. Margaret Jordan
(ADDRESS) Jefferson City, Missouri18. BURIAL, CREMATION, OR REMOVAL
PLACE River View Cem. DATE Sept-22- 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) W. B. Boyer20. FILED 9/27/10/39 W. B. Boyer Local Registrar.21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 21st 193922. I HEREBY CERTIFY, That I attended deceased from May 10th 1938, to Sept 21st 1939I last saw him alive on Sept 20th 1939. Death is said to have occurred on the date stated above, at 9 P. M.

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

Pulmonary Haemorrhage Date of onset VI

Other contributory causes of importance:

AtherosclerosisName of operation X Date of XWhat test confirmed diagnosis? X Was there an autopsy? X23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? X Date of injury X, 1939Where did injury occur? X (Specify city or town, county, and State)

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

Manner of injury XNature of injury X24. Was disease or injury in any way related to occupation of deceased? NoIf so, specify X(Signed) James Stewart M. D.(Address) 626 Jefferson St

80

11

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.....

Perd P. Dulle

....., Registered Apprentice No.

working under my personal supervision.

Signed *Perd P. Dulle*

Licensed Embalmer No. *3890*

P. O. Address *Jefferson Ct.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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32230 7
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1. PLACE OF DEATH

(a) County Cole Registration District No. 213
(b) Township _____ Primary Registration District No. 3014 Registered No. 221
(c) City Jefferson (d) Street No. _____ 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.

2. PRINT FULL NAME William A. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 6 28

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 _____ 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-21 1939

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

I last saw h. _____ 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:

Pulmonary Hemorrhage
Tobacco Pneumonia
arterio sclerosis
Date of onset 1938

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) James Stewart M. D.

(Address) 626 Jefferson St.

REGIS. FARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-32230