

DEC 11 1940

Registration District No. 949

Primary Registration District No. 6225

Registrar's No. 12

1. PLACE OF DEATH:
(a) County Wright
(b) City or town Grave Spring
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME James Andrew Jordan
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased July 25 67
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Grave Spring Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ?

MOTHER FATHER
12. Name Unknown
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Audra Pearson

(b) Address Grave Spring Mo

17. (a) Burial (b) Date thereof Oct 1 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Davis Cem

18. (a) Signature of funeral director R. M. Garner

(b) Address Grave Spring

19. (a) 10-19-40 (b) C. H. Hambley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wright
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 30 day 1940
year _____ hour 7 AM minute _____ M.
21. I hereby certify that I attended the deceased from Sept 29, 1940 to Sept 30, 1940
that I last saw him alive on Sept 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration _____

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

829 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. V. Hough (M. D. or other) _____

Address Wright Mo Date signed 10-16-40

RECEIVED

District Health Officer No 6.

District File Number ~~1240-2960~~

Date Filed DEC 6, 1940

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.....

F. P. Steffe

....., Registered Apprentice No.....

working under my personal supervision.

Signed *F. P. Steffe*

Licensed Embalmer No. 3221

P. O. Address monmouth ind

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.