

FEB 18 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

4465

Registration District No. 796

Primary Registration District No. 3038

State File No. \_\_\_\_\_

Registrar's No. 23

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH Saline

(a) County Saline

(b) City or town Marshall

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

837 N. Odell  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
All her life

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Marshall  
(If outside city or town limits, write "RURAL")

(d) Street No. 837 N. Odell  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Missouri Ann Jordan

3. (b) If veteran, name war \_\_\_\_\_ X

3. (c) Social Security No. \_\_\_\_\_ X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28  
year 1941 hour 8 minute 30 A.M.

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Robert Wm. Jordan

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 1, 1866  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 10, 1940 to Jan 28, 1941  
that I last saw her alive on Jan 28, 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 5 Days 27 If less than one day  
hr. \_\_\_\_\_ min.

Immediate cause of death Chronic Myocarditis

Duration ?

9. Birthplace Marshall 1, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Bacterial pneumonia  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

11. Industry or business \_\_\_\_\_

12. Name Richard Hicks

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant R H Jordan

(b) Address 837 N Odell

17. (a) Burial (b) Date thereof Jan. 30 '41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director J. Leslie Sumner

(b) Address 1-29-41 Marshall Mo

19. (a) 1-29-41 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) D

Address Marshall, Mo. Date signed 1-29-41

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7-12-68

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 *J. Leslie Sumner*  
Licensed Embalmer No. *3235*  
P. O. Address *Manchester, N.H.*

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, fact should be so stated above.