

FILED MAY 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15064

Registration District No. 501

Primary Registration District No. 4804

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Linneus Mo.

(c) Name of hospital or institution:
Linn County, Mo. Infirmary. 5
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 11 Years
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME MARY AGNES JOURDEN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife John W. Jourden

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

7. Birth date of deceased Feb. 20 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	1	29	hr. min.

9. Birthplace unknown
(City, town, or county) (State or foreign country)

10. Usual occupation resident of infirmary

11. Industry or business _____

MOTHER FATHER

12. Name Thomas McGuire

13. Birthplace County Galloway Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Honney

15. Birthplace County Galloway, Ireland.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas McGuire

(b) Address Kathville Mo

17. (a) Burial (b) Date thereof April 23-4
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Killaird

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo.

19. (a) April 23-41 (b) Maud I Webb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State V (b) County 58

(c) City or town _____
(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 April day 19
— year 1941 hour _____ minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 22
_____ 1941 to April 17 1941
and that death occurred on the date and hour stated above.

that I last saw her alive on April 17 1941

Immediate cause of death Carcinoma of Liver Duration 640

Due to _____

Due to 468

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
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? _____

863 While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Boyd Haley (M. D. or other) Cath

Address Brookfield Date signed 4/23/41

1 X1931

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. DO NOT WRITE IN BLACK INK—MAKE A PERMANENT RECORD

Registration District No. 501

Primary Registration District No. 4304

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Linn
(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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Agnes Jordan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 1 29 _____ min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-23-1954 (b) Maud J Webb
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH month april 19 19
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____
that I last saw _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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?

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

23. Signature Roy R. Haley (M. D. or other)

Address Brookfield Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

