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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36274

State File No.

Registrar's No. **4103**

FILED NOV. 19 1942/49
Registration District No.

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **General Hospital No. 20**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10-28-42-11-1-42**
(Specify whether years, months or days) **6 years**

In this community **6 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **2414 Highland**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **0**

3. (a) PRINT FULL NAME **EATHEL JORDAN**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **496-01-2178**

4. Sex **Male**

5. Color or race **Negro**

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

6. (b) Name of husband or wife **Ruth Jordan**

6. (c) Age of husband or wife if alive **38** years

7. Birth date of deceased **March 3 1896**
(Month) (Day) (Year)

8. AGE: Years **46** Months **7** Days **28**
If less than one day hr. min.

9. Birthplace **Little Rock Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Tin Handler**

11. Industry or business **Business**

12. Name **Richard Jordan**

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

14. Maiden name **Emma Hill**

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

16. (a) Informant **Record Clerk**
(b) Address **Record Clerk**

17. (a) **Burial** (b) Date thereof **11-6-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Brady funeral Home**

(b) Address **1708 Tracy**

19. (a) **11-5-42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **1**
year **1942** hour **12** minute **45 a.m.**

21. I hereby certify that I attended the deceased from **October 28 1942** to **November 1 1942**
that I last saw him alive on **November 1 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Mesentery Thrombosis**

Due to **Congestive Heart Failure**

Due to **Syphilitic heart disease**

Other conditions **30E**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **Same as above**

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) Means of injury

23. Signature **J. P. Turner** (M.D.)
Address **Gen. Hosp. #2-600 E. 222** Date signed **11-3-42**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4103

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME Cathel Jordan

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

4. Sex M. 5. Color Col 6. (a) Single, widowed, married, divorced, Married

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
46 7 28 h. 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) (Burial, cremation, or removal) (b) Date thereof 11-6-42
(Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem.

18. (a) Signature of funeral director.....

(b) Address 11/5/42 M. M. Crowe

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(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 Nov. day 1
year 1942 hour minute M.

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

Immediate cause of death.....

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?

(Specify type of place) While at work? (c) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S.36274. 1942