

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 5 1943**  
Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 812

Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
343 N. Wheeling  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 343 N. Wheeling  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Jordan  
3. (b) If veteran, name war -- 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 16 year 1943 hour \_\_\_\_\_ minute 12:40 P.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lillian May Arnold Jordan 6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased: April 16, 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 1942 to Feb. 16, 1943 that I last saw him alive on Feb. 16, 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 10 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Decompensated myocarditis 1 yr.  
Essential Hypertension 10 yrs.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Retired  
11. Industry or business \_\_\_\_\_  
12. Name James J. Jordan  
13. Birthplace No Record  
(City, town, or county) (State or foreign country)

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

14. Maiden name Henrietta Williams  
15. Birthplace Dayton, Ohio  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Lillian May Jordan  
(b) Address 343 N. Wheeling

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 2-18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt Washington Cemetery  
18. (a) Signature of funeral director Sheil Funeral Home  
(b) Address 6606 Indian Ave. K.C. Mo.  
19. (a) 2-16-43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature J. J. Socik (M.D. or other) Do.  
Address 5902 1/2 John Date signed 2/16/43

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

MOTHER FATHER

5902 St John

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**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.**