

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2324**

FILED FEB 14 1945

Primary Registration District No. **3024**

Registrar's No. **2**

1. PLACE OF DEATH:
(a) County **Howard**
(b) City or town **Fayette Missouri**
(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 **1**
(Specify whether
In this community **All his life**
years, months or days)

3. (a) PRINT FULL NAME **Frank Jurdan**
3. (b) If veteran, name war _____
3. (c) Social Security No. **unknown**

4. Sex **Male** 5. Color or race **Black**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Reberta Bright**
6. (c) Age of husband or wife if alive **-** years
7. Birth date of deceased **Aug. 4 1863**
(Month) (Day) (Year)

8. AGE: Years **81** Months **5** Days **4**
If less than one day
hr. min.

9. Birthplace **Howard County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farm Hand**

11. Industry or business _____
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 **Miss Claude McMurray**
(b) Address **Fayette, Missouri**

17. (a) **Burial** (b) Date thereof **1-10-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Fayette City Cemetery**

18. (a) Signature of funeral director **Ralph A. Carr**
(b) Address **Fayette, Missouri**

19. (a) **1-9-1945** (b) **Conrad W. Miller**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Howard** **45**
(c) City or town **Fayette** **1**
(If outside city or town limits, write "RURAL") **1**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **8**
year **1945** hour **10** minute **am**
21. I hereby certify that I attended the deceased from **death** 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 **Coronary Thrombosis**
Due to **Chr. Myocarditis**

Duration
1/2 hr.
?

Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: **g. s. h.**
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 **in**
23. Signature **W. B. Bloomer M.D.** (M. D. or other)
Address **Fayette, Mo.** Date signed **1-9-45**

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

5
1
1

1221

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-13-45

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 Raymond A. Carr

Licensed Embalmer No. 3340

P. O. Address Jayette Mo.

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.