

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8654**
Registrar's No. **1149**

FILED MAR 29 1946
Registration District No. **117**

Primary Registration District No. **1002**

18
3
8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:
Children's Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 6 Days
(Specify whether years, months or days)

In this community 6 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jordan, Judith Ann

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F / 5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased: NoV 17 1944
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>24</u>	
	<u>3</u>	<u>22</u>	hr. _____ min.

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

10. Usual occupation infant

11. Industry or business

12. Name Mackie Manel Jordan

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

14. Maiden name Rosetta Thene Krane

15. Birthplace Mt. Washington, K.C. Mo (Section)
(City, town, or county) (State or foreign country)

16. (a) Informant Mother & Father

(b) Address 829 Ewing, K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-45
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Blackman

(b) Address K.C. Mo

19. (a) 3-12-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

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" and name of township)

(d) Street No. 829 Ewing, K.C. Mo (Section)
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 - 11 day
year 1945 hour 11:00 minute exp.M.

21. I hereby certify that I attended the deceased from 3-5, 1945, to 3-11, 1945;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus
Spinal Bifida

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 57a

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Duration Birth
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) (c) Means of injury _____

23. Signature Humbly (M. D. or other) _____
Address 1624 Perry Blvd Date signed 3-12-45

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 W. O. Blackman

Licensed Embalmer No. 3639

P. O. Address N. C. 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.