S. No. 300
V. 10.48

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

FILED OCT 13 1949

45061-49
#76053

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31892

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 8407

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3715 Olive St.,

3. NAME OF DECEASED (Type or Print)
a. (First): BABY
b. (Middle): BOY
c. (Last): JOURDAN

4. DATE OF DEATH (Month) (Day) (Year): July 28th, 1949

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): premature infant
8. DATE OF BIRTH: 7/28/49
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min. 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: James Jourdan
13b. MOTHER'S MAIDEN NAME: Louise Williams
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Delivery — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 159
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 776X

22. *I hereby certify that I attended the deceased from* 7/28/49, 19___, *to* 7/28/49, 19___, *that I last saw the deceased alive on* 7/28/49, 19___, *and that death occurred at* 11:43 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John C. Crowell M.D.
23b. ADDRESS: 1515 Lafayette Ave.,
23c. DATE SIGNED: 7/29/49

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: SEP 30 1949
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG. SEP 30 1949
REGISTRAR'S SIGNATURE: J. B. Lacaster
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

(position)

d. ADDR

c. (Last)

E OF BIRTH

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 ....., Student Embalmer No. ....., working under my personal supervision.

Student ..... Student Embalmer

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.

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31892

BIRTH NO. 45061-49 #76053 REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 8407

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo. c. LENGTH OF STAY (In this place)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.	d. STREET ADDRESS (If rural, give location) 3715 Olive St.,

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Ray c. (Last) Jordan ~~BABY~~ ~~BOY~~ ~~JOURDAN~~

4. DATE OF DEATH (Month) (Day) (Year) July 28th, 1949

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) premature infant

8. DATE OF BIRTH 7/28/49

9. AGE (In years last birthday) If under 1 year: Months, Days; If under 1 hrs.: Hours, Min. 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Leon Jordan ~~James Jourdan~~

13b. MOTHER'S MAIDEN NAME Alma Louise Williams

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

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21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 159

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 776X

22. *I hereby certify that I attended the deceased from* 7/28/49, 19__, *to* 7/28/49, 19__, *that I last saw the deceased alive on* 7/28/49, 19__, *and that death occurred at* 11:43 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) John C. Crouse MD

23b. ADDRESS 1515 Lafayette Ave.,

23c. DATE SIGNED 7/29/49

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE SEP 30 1949

24c. NAME OF CEMETERY OR CREMATORY Anatomical Board

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. SEP 30 1949

REGISTRAR'S SIGNATURE J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

Items #3, 13a, b, amended by affidavit of mother 4-28-99