

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26992

FILED AUG 10 1951

Registrar's No. 3289

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 32 yrs.		d. STREET ADDRESS (If rural, give location) 440 N. Wheeling	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		3018	
3. NAME OF DECEASED (Type or Print) a. (First) Lillian	b. (Middle) M.	c. (Last) Jordan	4. DATE OF DEATH (Month) 7 (Day) 30 (Year) 51
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid	8. DATE OF BIRTH 9/13/1895
9. AGE (In years last birthday) 57 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser	11. BIRTHPLACE (State or foreign country) No Rec	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles F Richardson	13b. MOTHER'S MAIDEN NAME Molly Penigen	14. NAME OF HUSBAND OR WIFE Dec, _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 488-22-4482	17. INFORMANT'S SIGNATURE OR NAME Donald Arnold son 440 No. Wheeling K.C., Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		3018	
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 23, 19 51, to July 30, 19 51, that I last saw the deceased alive on July 30, 19 51, and that death occurred at 8 P. m., from the causes and on the date stated above.			
23a. SIGNATURE B.I. Burns (Degree or title)		23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 7-31-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/1/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG 8-1-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sheil Funeral Home K. C., Mo.	

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

*Dr. Robbins*

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed *John P. Sheil* .....

Licensed Embalmer No. *3625* .....

P. O. Address *K. 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.