

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35235**  
Registrar's No. **9105**

FILED NOV 2 1951

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

|   |  |  |   |   |   |  |   |  |
|---|--|--|---|---|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>  |   | Registrar's No. <b>9105</b>  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo</b><br>b. COUNTY _____ |   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town OR St. Louis, Missouri)   |  | c. LENGTH OF STAY (In this place) <b>3 mos. &amp; 3</b>  |   | c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis 2109</b>                                      |   | d. STREET ADDRESS (If rural, give location) <b>1150 N. PLEASANT ST.</b>          |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY INFIRMARY HOSPITAL</b>  |  |  |   |   |   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>MARTIN</b>   |  | b. (Middle) <b>J.</b>  |   | c. (Last) <b>JORDAN</b>   |   | 4. DATE OF DEATH (Month) <b>10</b> (Day) <b>15</b> (Year) <b>1951</b>            |   |  |
| 5. SEX <b>M</b>   |  | 6. COLOR OR RACE <b>W</b>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>9</b>   |   | 8. DATE OF BIRTH <b>May 27 1876</b>  |   |  |
| 9. AGE (In years last birthday) <b>75</b>   |  | IF UNDER 1 YEAR Months _____ Days _____  |   | IF UNDER 24 HRS. Hours _____ Min. _____   |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired laborer</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b> |   | 11. BIRTHPLACE (State or foreign country) <b>Ireland-4</b>                              |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13a. FATHER'S NAME <b>Anthony Jordan</b>  |  |  | 13b. MOTHER'S MAIDEN NAME <b>Anne McNamara</b>    |   |   | 14. NAME OF HUSBAND OR WIFE <b>Deceased</b>                                      |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____   |  | 16. SOCIAL SECURITY NO. _____  |   | 17. INFORMANT'S SIGNATURE OR NAME <b>John Jordan</b> ADDRESS <b>9445 Duenke Dr.</b>   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Generalized arteriosclerosis</b><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>5 days</b><br><b>years</b> |  |
| 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? <b>4570</b>  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>7/12</b> <sup>1951</sup> , to <b>10/15/</b> <sup>1951</sup> , that I last saw the deceased alive on <b>10/15/</b> <sup>1951</sup> , and that death occurred at <b>9:10 A.m.</b> , from the causes and on the date stated above. |  |  |   |   |   |  |   |  |
| 23a. SIGNATURE <b>George Oster, M.D.</b> (Degree or title) <b>M.D.</b>  |  |  | 23b. ADDRESS <b>5600 Arsenal St.</b>              |   |   | 23c. DATE SIGNED <b>10/15/51</b>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  | 24b. DATE <b>10/18/51</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>   |   | 24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>               |   |  |
| DATE RECEIVED <b>OCT 16 1951</b>  |  | REGISTRAR'S SIGNATURE <b>E. Earl Smith M.D.</b>  |   |   | FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan Funeral Dir.</b> ADDRESS <b>2849 N. Euclid</b> |  |   |  |

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

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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 Francis Hillman.....

Licensed Embalmer No. 3565.....

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.