

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25337**

FILED AUG 7 - 1953

BIRTH NO. _____ REG. DIST. NO. **150** PRIMARY REG. DIST. NO. **5572** Registrar's No. **148**

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 Rural Prairie Township		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Blue Springs	
c. LENGTH OF STAY (in this place) 8hrs		d. STREET ADDRESS (If rural, give location) None	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Phonda	b. (Middle) Darlene	c. (Last) Jordan	4. DATE OF DEATH (Month) (Day) (Year) 7 12 1953
-------------------------------------	--------------------------	----------------------------	-------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 7 12 1953	9. AGE (In years last birthday) 8	10. UNDER 1 YEAR Months 0 Days 0	11. UNDER 1 HR. Hours 0 Min. 0
----------------------	-------------------------------	--	-----------------------------------	--	--	--

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) Jackson Co Mo	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	---

13a. FATHER'S NAME Charles Jordan	13b. MOTHER'S MAIDEN NAME Betty Ruth Cafferty	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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Charles Jordan	ADDRESS Blue Springs, Mo
--	-------------------------------------	---	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephaly & meningitis etc		DUPLICATE		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 752X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	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 **in Mo** on **7-12, 1953**, to **7-12, 1953**, that I last saw the deceased alive on **7-12, 1953**, and that death occurred at **10 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE John C. Chirruschein MD	(Degree or title) MD	23b. ADDRESS Independence Mo	23c. DATE SIGNED July 5 1953
---	-----------------------------	-------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE 7-15-53	24c. NAME OF CEMETERY OR CREMATORY Leis Summit	24d. LOCATION (City, town, or county) (State) Leis Summit Mo
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. 7-21-53	REGISTRAR'S SIGNATURE W. B. Langford	25. FUNERAL DIRECTOR'S SIGNATURE W. B. Langford	ADDRESS Leis Summit Mo
---	---	--	-------------------------------

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

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Not Embalmed

[Handwritten Signature]
383
[Handwritten Address]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.