

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29719**

No. 300
10.48

FILED AUG 25 1953

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3061 Registrar's No. 287

1. PLACE OF DEATH a. COUNTY ST. FRANCIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. FRANCIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FLAT RIVER		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FLAT RIVER <u>09420</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 101 EAST MAIN		d. STREET ADDRESS (If rural, give location) 101 EAST MAIN	

3. NAME OF DECEASED (Type or Print) a. (First) Lydia b. (Middle) E. c. (Last) JORDAN			4. DATE OF DEATH (Month) (Day) (Year) Aug. 17, 1953		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 4, 1895	9. AGE (In years of last birthday) 58	10. MONTHS 2 11. DAYS 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Reynolds Co. MO. USA	

13a. FATHER'S NAME MARION RANDOLPH		13b. MOTHER'S MAIDEN NAME JEMIMA PARKER		14. NAME OF HUSBAND OR WIFE JAMES JORDAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs Tillman Boston, Flat River			

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) Carcinoma tonsil		INTERVAL BETWEEN ONSET AND DEATH 9 months
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adenoma left breast - Recurrent in both lungs, liver. DUE TO (c) All of my abdominal bodies + bottles		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Humeri		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Adenoma carcinoma - left breast - 1948. 170x	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 Jan 1953, to Aug 17, 1953, that I last saw the deceased alive on Aug 16, 1953 and that death occurred at 9:21 m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Geo. R. Walters, M.D. (Degree or title)	23b. ADDRESS Farmington Mo.	23c. DATE SIGNED 8-18-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Aug. 19, 1953	24c. NAME OF CEMETERY OR CREMATORY ST. FRANCIS MEM. PARK
24d. LOCATION (City, town, or county) (State) Bonne Terre, MO.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Raymond Caldwell, Flat River, Mo.
DATE REC'D BY LOCAL REG. Aug 18, 1953	REGISTRAR'S SIGNATURE Esther Pudloff	

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

942
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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 R. Caldwell

Licensed Embalmer No. 2551

P. O. Address Flat River, 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. \