

Death, Welfare, Public Service, 300-56, All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28636

FILED SEP 7 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's **6812**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE *ON 1-3950*

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>St Louis</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>University City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>			Length of stay in 1b		d. STREET ADDRESS <b>6744 Olive St Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>A</b> Last <b>Jordan</b>				4. DATE OF DEATH Month <b>7</b> Day <b>19</b> Year <b>56</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-03</b>		9. AGE (In years last birthday) <b>52</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>Housewife</b>			100. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unk Hopkins</b>				14. MOTHER'S MAIDEN NAME <b>Unk</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Bernard A Jordan</b> Address <b>6744 Olive St Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>Hypertension</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>331X</b>							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>6-18-50</b>		20f. CITY, TOWN, OR LOCATION <b>7-19-56</b>		COUNTY _____ STATE _____			
21. I attended the deceased from <b>6/18/50</b> to <b>7-19-56</b> and last saw her/him alive on <b>7-19-56</b> Death occurred at <b>10.20 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>L.P. Hayden</b> <i>L.P. Hayden M.D.</i> (Degree or title)				22b. ADDRESS <b>730 Hodiamont</b> <b>730 Hodiamont</b>		22c. DATE <b>7-20-56</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7-23-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Co. Mo.</b>			
24. FUNERAL DIRECTOR <b>Jos W Clark Funeral Home Inc</b> <b>1125 Hodiamont Ave</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 21 1956</b>		26. REGISTRAR'S SIGNATURE <i>J Carl Smith M.D.</i>			

**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.....  
Signature of Student Embalmer

Signed *Stanley H. Digo*  
Licensed Embalmer No. *4*  
P. O. Address *H. D.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.