

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14877

STATE FILE NUMBER  
3667

4215-57

FILED APR 26 1957

318

1003

Registration District No. Primary Registration District No. Registrar's No.

Health,  
& Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK-INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, MISSOURI</b>		c. CITY OR TOWN <b>ST. LOUIS, MISSOURI</b>	
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1</b>		Length of stay in lb <b>25</b> STREET ADDRESS <b>5736 PAGE</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Jordan</b>		4. DATE OF DEATH <b>Jan. 5 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 5, 1957</b>
9. AGE (In years last birthday) <b>1 37</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	12. CITIZEN OF WHAT COUNTRY? <b>u. s. a.</b>
13. FATHER'S NAME <b>FLOYD JORDAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY JMCMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ST. LOUIS CITY HOSPITAL #1.</b>		Address	
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>Apnea neonatorum</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 57 min</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>7730</b>		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.)	
20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>		COUNTY STATE	
21. I attended the deceased from <b>1/5/57</b> to <b>1/5/57</b> and last saw her alive on <b>1/5/57</b> Death occurred at <b>5:10 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. B. Klein M.D.</b>		22b. ADDRESS <b>1515 Lafayette</b>	
22c. DATE SIGNED <b>1/8/57.</b>		23. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-30-57</b>		23b. DATE <b>4-30-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Rowland-Aker 410 1/2 Mandeville</b>		25. DATE RECD. BY LOCAL REG. <b>APR 17 '57</b>	
26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		26. REGISTRAR'S SIGNATURE <b>mdb</b>	

(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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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