

FILED MAY 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14879

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4170

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |   |  |  |  |
| a. COUNTY   |  |   |  | a. STATE <b>MISSOURI</b>  |   | b. COUNTY  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>      |  | c. CITY OR TOWN <b>ST LOUIS,</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA HOMER PHILLIPS HOSP.</b>   |  | Length of stay in lb  |  | d. STREET ADDRESS <b>3321 ABNER PLACE</b>   |   | (If outside, give location) Residence on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |   |  | 4. DATE OF DEATH  |   |  |  |  |
| First <b>JOSEPH</b>   |  | Middle <b>S.</b>  |  | Last <b>JOURDAN</b>   |   | Month <b>MAY 1,</b> Year <b>1957</b>   |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>JAN. 8, 1883</b>   |  |  |
| 9. AGE (In years last birthday) <b>74</b>   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CUSTODIAN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country) <b>EFFINGHAM ILLINOIS</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |
| 13. FATHER'S NAME <b>JOSEPH I, JOURDAN</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>EMMA WATKINS</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># 492-164876</b>   |  | 17. INFORMANT Address <b>KATIE JOURDAN 3321 ABNER PLACE</b>   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio Sclerosis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b> |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH                             |  |
| 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<br>Hour _____<br>a. m. _____<br>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  |   | COUNTY STATE   |  |  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at <b>11:50 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |  |   |   |  |  |  |
| 22a. SIGNATURE (Degree or title) <b>Joseph M. Stroob</b>  |  |   |  | 22b. ADDRESS <b>1300 Clark</b>  |   | 22c. DATE SIGNED <b>5/2/57</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <b>5/1/57</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>VAHALLA CEMETERY</b>  |   | 23d. LOCATION (City, town, or county) (State) <b>ST LOUIS COUNTY MO.</b>   |  |  |
| 24. FUNERAL DIRECTOR <b>STROOT - CARROLL</b>  |  |   | ADDRESS <b>4600 NATURAL BRIDGE</b>   |   | 25. DATE RECD. BY LOCAL REG. <b>MAY 2 '57</b> |  | 26. REGISTRAR'S SIGNATURE <b>Carl Smith mo</b><br><i>mjs</i> |  |

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
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

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 M. W. Rueter

Licensed Embalmer No. 486

P. O. Address St. Louis

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.