

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016313
STATE FILE NUMBER

FILED MAY 15 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1199

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Missouri		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hosp.		d. STREET ADDRESS 6310 a Arsenal	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WALTER JORDAN		4. DATE OF DEATH Month Day Year May 1 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil for 22 years		10b. KIND OF BUSINESS OR INDUSTRY Reg. Clerk	11. BIRTHPLACE (City and state or country) Mississippi
13a. FATHER'S NAME James H. Jordan		13b. MOTHER'S MAIDEN NAME Rachel Casey	14. NAME OF HUSBAND OR WIFE Laura Jordan
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. -	17. INFORMANT Address Koch Hospital records, Koch, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary T.b & bronchopneumonia DUE TO (b) Metastatic carcinoma DUE TO (c) 002XH 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
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 <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 10-18-58 to 5-1-59 and last saw her/him alive on 5-1-59 Death occurred at 3:35 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Bernard Friedman M.D.		22b. ADDRESS Robt. Koch Hosp., Koch, Mo.	
22c. DATE SIGNED 5-1-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 4 59	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard	23d. LOCATION (City, town, or county) (State) St. Louis City, Mo.
24. FUNERAL DIRECTOR ADDRESS E. J. Schnur 3125 Lafayette		25. DATE RECD. BY LOCAL REG. 5-2-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas R. Newrick*

Licensed Embalmer No. *8793*
P. O. Address *3125 Lafayette*

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.