

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

Minberg
35234

1. PLACE OF DEATH

County *Franklin*

Registration District No. *796*

Township

Primary Registration District No. *4180*

City *Union* (No.)

File No.
Registered No.
St. Ward)

2. FULL NAME *Golden Tennessee Gardner*

(a) Residence No. *Union Mo.* St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Ann Gardner*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 11, 1883*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 10 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Champion City Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Alber Bell*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Champion City Mo.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Janice Park*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Park County Mo.*
(STATE OR COUNTRY)

14. INFORMANT *Ann Bell*
(Address) *Union Mo*

15. FILED *Oct 10, 1928 E.A. Stinberg*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 9 1928*

17. I HEREBY CERTIFY That I attended deceased from *Sept 2*, 1928, to *Oct 9*, 1928, that I last saw h. *iv* alive on *Oct 9*, 1928, and that death occurred, on the date stated above, at *4:00 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Infarction
15B
19413 (duration) yrs. mos. da. *14*

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. *Her Home*

() DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *10 11*

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical*
E.A. Stinberg, M. D.
(Signed) *Oct 10, 1928* (Address) *Union Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Pleasant Hill Cemetery, Talla Ridge* DATE OF BURIAL *Oct 11 1928*

20. UNDERTAKER *Otto & Co* ADDRESS *Washington Mo*

WRITE POSITELY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1928

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin
Towship ..
City Union (No.) St. Ward)

Registration District No. 296
Primary Registration District No. #180

File No.
Registered No.

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Oct 10 1928 E. A. Stierbagen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9 1928

17. I HEREBY CERTIFY, That I attended deceased from that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Empioides
CONTRIBUTORY (SECONDARY) Secondary Abscesses of
Foot (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. 185
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

ONLY, WITH UNFADING INK---TN IS A PERMANENT RECORD

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B. - Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN, should state CAUSE OF DEATH, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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