

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

Do not use this space.

14747

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1008**
 City *St. Louis* (No. *Congress City East # 1*) St. *6* Ward

File No.....
 Registered No. **4155**

2. FULL NAME

Herann Gardner
 (a) Residence. No. *1624* *Market* St. *25* 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 *Male*
 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26-64

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Carpenter*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *N.Y.*
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER *Hudson*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Hudson*
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Hudson*
 (STATE OR COUNTRY)

14. INFORMANT *J. W. Kerner*
 (Address) *Corcoran Court*

15. FILED *15* 19*30* *Max C. Gardner*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 22 1930*

17. *No Physician attended*
 I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: *9:15 a.m.*
Pneumonia
10th
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *10/10*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) *J. W. Kerner, M.D.*
4/25 1930 (Address) *Dep. Coroner*

*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 *Fort Plaine U. S.* DATE OF BURIAL *4/28 1930*

20. UNDERTAKER *Ziegenheim Bros.* ADDRESS *2621 Cherokee*

K. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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31

