

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

Do not use this space.

**3207**

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis (No. City Hospital)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 421  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Charles E. Gardiner  
(a) Residence. No. Swan Stone St. 25 Ward.  
(Usual place of abode) 803 N. 6th  
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**(GARDINER)**

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male  
**4. COLOR OR RACE** White  
**5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Don't know  
**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
about 53  
**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work. Labourer 39  
(b) General nature of industry business, or establishment in which employed (or employer) Carpenter  
(c) Name of employer

**2 MEDICAL CERTIFICATE OF DEATH**  
**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 9 31  
**17. I HEREBY CERTIFY** That I attended deceased from Jan 6 to Jan 9 1931 and that I last saw him alive on Jan 9 1931 and that death occurred, on the date stated above, at 950  
**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chr. Myocarditis  
930  
97 (duration) .....yrs. ....mos. ....ds.  
**CONTRIBUTORY (SECONDARY)** Arterio-sclerosis  
(duration) .....yrs. ....mos. ....ds.

**18. WHERE WAS DISEASE CONTRACTED**  
IF NOT AT PLACE OF DEATH.....  
**19. DID AN OPERATION PRECEDE DEATH.** No DATE OF.....  
**20. WAS THERE AN AUTOPSY?** No  
**WHAT TEST CONFIRMED DIAGNOSIS** Clinical  
(Signed) James Simpson M.D.  
(Address) City St. Louis

**9. BIRTHPLACE (CITY OR TOWN)** Indiana  
(STATE OR COUNTRY) 2  
**10. NAME OF FATHER** August Gardiner  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Indiana  
(STATE OR COUNTRY)  
**12. MOTHER'S NAME OF MOTHER** Luella  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** Indiana  
(STATE OR COUNTRY)  
**14. INFORMANT** Mar E. Starker  
(Address) City St. Louis  
**15. FILED** 11 1931  
REGISTRAR

\*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** Calvary Cem. **DATE OF BURIAL** Jan. 12, 1931.  
**20. UNDERTAKER** Joe W. Clark **ADDRESS** 1125  
Madison

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.

Gardner.