

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

Do not use this space.

38510

1. PLACE OF DEATH

County Tenniscot
Township Cassford
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 603
Primary Registration District No. 8865

File No. _____
Registered No. 136

2. FULL NAME

Ben Gardner

(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 Male 4. COLOR OR RACE Cal 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 22, 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 6 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

PARENTS

10. NAME OF FATHER Frank Gardner

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

12. MAIDEN NAME OF MOTHER Lila Rogers

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

14. INFORMANT Birders Gardner
(Address) Swift, Mo.

15. FILED 11-11-1931 J. E. Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 10th 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 1931, to Feb. 10, 1931, that I last saw him alive on Sept. 10, 1931 and that death occurred, on the date stated above, at 4:00 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS
"Congestive Chill"

Pericercious Vascularis
38 (duration) yrs. 2 mos. 9 ds.

CONTRIBUTORY (SECONDARY) 38 (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 History
(Signed) James S. Vickrey M. D.

11-11-1931 (address) Bridgemoor, 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 Swift, Mo. DATE OF BURIAL 11-11-1931

20. UNDERTAKER H. G. Davis ADDRESS Swift, Mo.

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

[The body of the document is almost entirely blank, with only a few faint, illegible marks and a small, dark smudge near the top center.]

**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 Pemiscot Registration District No. 653 File No. _____
 Township Concord Primary Registration District No. 5865 Registered No. 136
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Ben Gardner

(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>B</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) <u>April 22 - 1888</u>		
7. AGE	YEARS <u>43</u>	MONTHS <u>6</u>
	DAYS <u>18</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 10 - 1931
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Date of onset
Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) _____, M. D.
 (Address) _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

19. UNDERTAKER (ADDRESS) _____

20. FILED 11-11-1931 J. J. Johnson Registrar

SUPPLEMENTARY

THIS IS A PERMANENT RECORD
 AGE should be stated EXACTLY. PHYSICIANS SIGNATURE
 DEATH in plain terms, so that it may be properly understood.
 EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.
 UNTIL THEY ARE COMPLETE AS PRESCRIBED BY
 REGISTERS SHALL NOT RECEIVE A FEE FOR CERTIFICATE.

S-38510