

NOV 21 1935

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jackson
Township Kew
or
Village
or
City K.G. Mo.

Registration District No. 399
Primary Registration District No. 1002 File No. 32877
Registered No. 3057
(NO Simpson Major Sanit. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dr. William M. Gardner, Chillicothe Mo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE wh. 5 SINGLE MARRIED WIDOWED OF, DIVORCED Married
(Write the word)
6 DATE OF BIRTH Sept 21st 1867
(Month) (Day) (Year)
7 AGE 68 yrs. 1 mos. 4 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Doctor
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(City or town, State or foreign country) Livingston Co. Mo

10 NAME OF FATHER Daniel Gardner
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
12 MAIDEN NAME OF MOTHER Martha Smith
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Black Gardner
(Address) Chillicothe Mo

15 Filed 10/25 1935 35 m. m. Crow Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25th 1935
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 30th 1935 to Oct 25th 1935, that I last saw him alive on Oct 25th 1935, and that death occurred, on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism
W

CONTRIBUTORY (Secondary) arteriosclerosis
arterial hypertension
(Duration) 20 yrs. mos. ds.
(Signed) Norman F. B. Norman M. D.
Oct 21 1935 (Address) 3100 Euclid Ave Chillicothe Mo

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death.....yrs. 1 mos. 4 ds. In the State 68 yrs. 1 mos. 4 ds.
Where was disease contracted if not at place of death? Don't know
Former or usual residence Chillicothe Mo

19 PLACE OF BURIAL OR REMOVAL Chillicothe Mo DATE OF BURIAL 10-26 1935

20 UNDERTAKER F. B. Norman ADDRESS Chillicothe Mo

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.

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

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 4057
 City..... (No. Surgeon Major Amalarium)..... Ward.....

2. FULL NAME Dr Wm M Gardner

(a) Residence, No..... St..... Ward.....
 (Usual place of abode)

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. (If nonresident, give city or town and State)

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 Frankie D. Gardner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 21, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 2 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Doctor
 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) Sept 1, 1934 11. Total time (years) spent in this occupation 38

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Livingston County, Missouri - Farm

13. NAME David Gardner

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

15. MAIDEN NAME Martha Gardner

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

17. INFORMANT (ADDRESS) J. P. Gardner, 212 S. 1st St., Keokuk, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Chilwich, Mo. DATE Oct 26, 1934

19. UNDERTAKER (ADDRESS) Frank Norman, Chilwich, Mo.

20. FILED 10/25 1934 M. M. Cerone Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/25, 1934

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
 I last saw him..... 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).....

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

SUPPLEMENTARY

S-32877