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

41115
Do not use this space.

1. PLACE OF DEATH
(a) County Wayne
(b) Township or (c) City Piketon Dale / Grant City, Mo.
Registration District No. 988
Primary Registration District No. 4-14
Registered No. 14
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs VINA M. GARDNER
(a) Residence, No. ..... St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W	Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 23, 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	80	0	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knox County Illinois

FATHER
13. NAME Alexander McDonald
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Logan Pennsylvania

MOTHER
15. MAIDEN NAME Nancy Bingham
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Ohio

17. INFORMANT (ADDRESS) Mrs Kate Lewis Grant City Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grant City Mo. DATE 11/3 1939

19. FUNERAL DIRECTOR (NAME) Jno C. Dunfee
(ADDRESS) Grant City Mo.

20. FILED 12/9, 1939 Fred Mull M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1939, to Nov 2, 1939
I last saw her alive on Nov 1, 1939, Death is said to have occurred on the date stated above, at 2:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Nephritis, Coma	Oct 28

Other contributory causes of importance:
Hypertension Heart

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Autopsy? No

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? No
If so, specify .....
(Signed) R. Mason Gill M.D.
(Address) Grant City Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

9562

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

41115

Do not use this space.

1. PLACE OF DEATH
(a) County Worth — Registration District No. 903
(b) Township — Primary Registration District No. 45-45 — Registered No.
(c) City Grant City (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Vina M. Gardner

(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Wid

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.
	80	0	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED ....., 19.... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2, 1939

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
Myocarditis	
Nephritis	
Chronic	

Other contributory causes of importance:

Hypertensive Heart	

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) P. L. Rose M.D., M. D.
(Address) Grant City Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.