

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16436**
Registrar's No. **6**

Registration District No. **949**

Primary Registration District No. **6225**

1. PLACE OF DEATH:

- (a) County Wright
 (b) City or town Proctorville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7
(Specify whether)
 In this community 635
years, months or days

3. (a) PRINT FULL NAME Charles J. Gardner

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased March 21 35
(Month) (Day) (Year)

8. AGE: Years 4 Months 1 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Loring (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name William J. Gardner
 13. Birthplace Mo
 14. Maiden name Christa Stantley
 15. Birthplace Fairview
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William J. Gardner
 (b) Address _____

17. (a) burial (b) Date thereof 4 25 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boyer Cem

18. (a) Signature of funeral director R. M. Garner

(b) Address Grow Springs Mo

19. (a) 4-24-40 (b) C. J. Campbell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
 year 1940 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 30, 1940, to April 24, 1940
 that I last saw him alive on April 23, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia abscess of lung Duration 2 weeks

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Pus in lungs when tube was inserted
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

- (a) fall (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
at work (Specify type of place) (e) Means of injury _____

23. Signature A. C. Worthey (If other) _____
 Address Hartsville Mo Date signed 4-24-40

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. WHILE FADING BLACK INK—MAKE A PERMANENT RECORD. I 10851

RECEIVED

District Health Officer No. 6,

District File Number 540-1326

Date Filed MAY 14 1940

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16436

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 949

Primary Registration District No. 6225

Registrar's No.

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Wright T.P.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright
(c) City or town Loring mo
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location) Rural
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME

Chas. Eugene Gardner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 1 3 hr. min.

9. Birthplace Loring Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-12-40 (b) C. M. Howell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature F. C. Wether (M.D. or other)

Address Harshille Mo Date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTAL

