No. 3
1-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19405

Registration District No. 765 — JUN 1 1940

Primary Registration District No. 4460

Registrar's No. 17

1. PLACE OF DEATH

(a) County St. Clair

(b) City or town Osceola
(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 no. (Specify whether years, months or days) In this community killed on highway

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3539 Central
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Lewis H. Gard 1.30

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary S. Gard

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

7. Birth date of deceased April (Month) 5 (Day) 1909 (Year)

8. AGE: Years 31 | Months 1 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Mo (State or foreign country)

10. Usual occupation Retail Clerk

11. Industry or business

FATHER
12. Name Obed H. Gard
13. Birthplace New Canton (City, town, or county) Don't Know (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace Blanche Johnson New Canton (City, town, or county) Don't Know (State or foreign country)

16. (a) Informant Mrs. Mary S. Gard

(b) Address 3539 Central

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 5/11/40 (Month) (Day) (Year)

(c) Place: ~~Burial or cremation~~ Kansas City, Mo.

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) 6-1-1940 (Date received local registrar) (b) Ruth Seevers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1940 hour 3 ~~P.M.~~ A.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Skull Crushed in Auto accident. — Duration

Due to ____

Due to ____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

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) Accident

(b) Date of occurrence May 11 1940

(c) Where did injury occur? Osceola (City or town) St Clair (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? U.S. Highway (Specify type of place)

While at work no (e) Means of injury ____

23. Signature [illegible] (M. D. coroner or other)

Address Osceola Date signed May 11-40

(Licensed Embalmer's Statement on Reverse Side)

210m
95

RECEIVED
District Health Officer No. 7
District File Number 6-40-862
Date Filed 6-11-40

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 O S Hullop

Licensed Embalmer No. 2097

P. O. Address Osceola

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

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

S. No. 2B
1—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19405-

Registration District No. 765-

Primary Registration District No. 4460

Registrar's No.

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

ROWENA MOORE

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Osceola
(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
In this community (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME Lewis H Gard

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 m

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 31 Months 1 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month may day 11 year 1940 hour minute M.

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

Immediate cause of death Skull Crushed in auto accident — Duration

Due to Non Collision car overturned on curve at high speed

Due to

Other conditions (Include pregnancy within 3 months of death) 2 10 PM 28

Major findings:
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) 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. S. Hull (M. D. or other)
Address Osceola Mo. Date signed

. No. 2B
—2-14-40
22659

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19405

Registration District No. 765 Primary Registration District No. 4460 Registrar's No.

1. PLACE OF DEATH:

(a) County St Clair

(b) City or town Osceola (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 (Specify whether years, months or days)

In this community

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.

3. (a) PRINT FULL NAME Lewis H. Gard

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 m

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
31	1	5	hr. min.

9. Birthplace Kansas City Mo (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace New Canton - Pike Co. Ill (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Blanch Johnson
15. Birthplace New Canton Ill (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-18-1940 (Date received local registrar) (b) Ruth Sievers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: 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) 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. S. Hull Coroner (M. D. or other)

Address Osceola Mo Date signed

SUPPLEMENTARY