

FILED AUG 3 1940
Registration District No. **407**

Primary Registration District No. **5415**

Registrar's No. **93**

1. PLACE OF DEATH:

(a) County **Franklin Boone Township**
(b) City or town **Boone Rural**
(c) Name of hospital or institution: **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **St Louis 20 years**
years, months or days

8. (a) PRINT FULL NAME **CHARLES W. GARNER**

8. (b) If veteran, name war **No 494-10-5604** 8. (c) Social Security No. **604**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Laura Millhouse** 6. (c) Age of husband or wife if alive, years
7. Birth date of deceased **Oct. 14 th 1884**
(Month) (Day) (Year)

8. AGE: Years **55** Months **8** Days **26** If less than one day hr. min.

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

10. Usual occupation **Plasterer**

11. Industry or business **Shell Oil Co**

12. Name **Edward Garner 9**

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

14. Maiden name **Sarah Kaufman**

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

16. (a) Informant **Laura Garner**

(b) Address **1622 Texas Ave**

17. (a) **July 23-1940** (b) Date thereof (Month) (Day) (Year)

18. (a) Signature of funeral director **Henry L. Heidemann**

(b) Address **6703 Glasgow St Louis**

19. (a) **7-21-40** (b) **Charles A. Schmidt**
(Date received locally) (Registrar's signature)

USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**
(c) City or town **St Louis Rural Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **1622 Texas Gerald mo**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **20**
year **1940** hour **13** minute **15** P.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 **Auto Accident** Duration
Fracture neck skull
left leg right arm

Due to _____
Due to **Head on Collision**

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

Major findings: _____
Of operations _____

Of autopsy **none**

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

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

(b) Date of occurrence **July 20 1940**

(c) Where did injury occur? **Gerald Pramba mo**
(City or town) (County) (State)

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

while at work? **no** (Specify type of job) (e) Means of injury _____

23. Signature **Pho. T. Stoffer** (Name)
Address **St Louis mo** Date signed _____

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

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

210M
22

STATEMENT BY LICENSED EMBALMER

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25724

Registration District No. 1104

Primary Registration District No. 5415

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Boone T.P.
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Charles H. Garner

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 w

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 55 Months 8 Days 26 If less than one day _____ 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(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 July day 20
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Auto accident Duration _____

Due to fracture neck skull
Left leg right arm

Due to Head on collision
of two automobiles

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?

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

23. Signature Geo. P. Stoffa (Physician)
Address Bullman (City or town) _____ Date signed _____

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

SUPPLEMENTARY

