

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27056

State File No.

Registrar's No. 6952

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week
(Specify whether _____)
In this community _____
years, months or days) _____

3. (a) PRINT FULL NAME FRANK LEE GARDNER
3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-18-5306

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Julia Gardner 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased February 21, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 25 hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Conductor, Mo. Pac. R. R. Co.

MOTHER FATHER { 12. Name unknown
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Julia Gardner
(b) Address Calioca Rock, Ark.

17. (a) Removal (b) Date thereof 8/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cotter, Ark.

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) AUG 16 1940 (b) J. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Stone
(c) City or town Calioca Rock NR
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1940 hour 1 minute 10 P M.

21. I hereby certify that I attended the deceased from Aug 10, 1940, to Aug 16, 1940, that I last saw him alive on Aug 16, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC FAILURE Duration 1 day

Due to HYPERTENSIVE HEART DISEASE

Due to HYPERTROPHY OF PROSTATE
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? _____

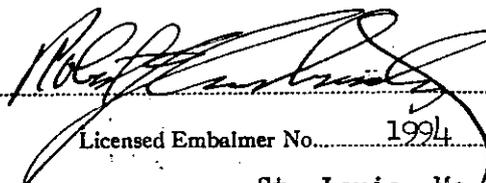
While at work? (Specify type of place) (e) Means of injury _____

23. Signature John T. Vandover (M. D. or other) MD
Address 1055 South Grand Date signed 8/16/40

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 .....
Licensed Embalmer No..... 1994
P. O. Address..... St. Louis, Mo.

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.