

S. No. 2  
OM-5-42  
5-17-39  
I X3287

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20365**  
Registrar's No. **2627**

FILED JUN 24 1943  
Registration District No. **749**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Nora-Rae Restorium 4309 Garfield  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Months  
(Specify whether  
In this community 18 Yrs  
years, months or days)

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. 309 Garfield  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bernice L. Gardner

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife No Record 6. (c) Age of husband or wife if alive Deceased  
7. Birth date of deceased January 25, 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
71 4 14 hr. min.

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

10. Usual occupation Practical Nurse

11. Industry or business Self

MOTHER FATHER { 12. Name William Henry Brown  
13. Birthplace No Record No Record  
(City, town, or county) (State or foreign country)  
14. Maiden name Jane Shoop  
15. Birthplace No Record No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Buckland  
(b) Address 4147 Francis

17. (a) Burial (b) Date thereof 6/12/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill Cem.

18. (a) Signature of funeral director Gates  
(b) Address 1901 Olathe Blvd. K.C. Kans.

19. (a) 6-10-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9th  
year 1943 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from March 2  
1943 to June 7 1943  
that I last saw her alive on June 7 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to Hypertension  
Arterio sclerosis

Other conditions 83a  
(Include pregnancy within 3 months of death)

Major findings: Of operations 83a! 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 D. J. Heary & Humber (M. D. or other) D.O.  
Address 428 1/2 E. 14th St. Date signed 6/10/43

Dr. C. W. Himmeler  
244 Jackson  
Be. 2445

MAY 12 1955

MAY 10 1954

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. 3991

P. O. Address.....

309 E. 67<sup>th</sup> St.

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, fact should be so stated above.

*X.P.M.*