No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 13 1944

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 8953

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2874

**1. PLACE OF DEATH:**

(a) County Missouri

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 35 YRS.
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 000

(a) State MO. (b) County 17

(c) City or town St. Louis 95
(If outside city or town limits, write "RURAL")

(d) Street No. 945 a Cabanne Court
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

**3. (a) PRINT FULL NAME** PHILLIP GARDNER

3. (b) If veteran, name war No

3. (c) Social Security No. 490-26-3585

4. Sex Male

5. Color or race Col

6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife Ada Gardner

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

7. Birth date of deceased 4 (Month) 25 (Day) 1887 (Year)

8. AGE: Years 56 Months 11 Days 30 If less than one day hr. min.

9. Birthplace Hickowood (City, town, or county) Tenn 1 (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business Mrs Addison 5820 Cates

FATHER
12. Name Gardner
13. Birthplace Tenn. 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Tenn. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Katie Warren
(b) Address 945 a Cabanne Court

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (Month) (Day) (Year)
(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director Allen Duilles
(b) Address 3506 Franklin Ave

19. (a) MAR 28 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 23
year 1944 hour 9 minute 56 a. M.

21. I hereby certify that I attended the deceased from March 6, 1944, to March 23, 1944
that I last saw him alive on March 23, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death colon cancer of colon with metastases to liver, Kidney, and retro-peritoneal nodes.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy same as above

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature M. C. Abney (M. D. or other)

Address BARNES HOSPITAL Date signed 3/28/44

(Licensed Embalmer's Statement on Reverse Side)

## 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.....James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 3506 Franklin

**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.**