

No. 2
-2.43
17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11469

State File No. _____

FILED APR 12 1945
Registration District No. _____

Primary Registration District No. 5725

Registrar's No. 32

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Hudson Macon Mo
(c) Name of hospital or institution? Still Wilderth Sanatorium
(d) Length of stay: In hospital or institution 9 mo. 5 da.
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County 9th
(c) City or town Wood City Iowa
(d) Street No. _____
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Margaret Gardiner
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month march day 13
year 1944 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from June 18
_____, 1943, to march 13, 1944
that I last saw her alive on march 13, 1944,
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 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 Sept 7 1868
(Month) (Day) (Year)

Immediate cause of death Senile Dementia with Inanition.
Due to _____
Due to _____

8. AGE: Years 75 Months 6 Days 6 If less than one day _____ hr. _____ min.

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

10. Usual occupation Retired house wife
11. Industry or business _____
12. Name James James
13. Birthplace Canada
14. Maiden name Elyza Lash Munro
15. Birthplace Canada
(City, town, or county) (State or foreign country)

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

16. (a) Informant George Gardiner
(b) Address 5209 Sioux City Iowa
17. (a) unusual (b) Date thereof Mar 14-44
(c) Place: burial or cremation Remrick Iowa
18. (a) Signature of funeral director Robert Skinner
(b) Address Macon Mo
19. (a) 4/4/44 (b) Ira B. Hunkler
(Data received local registrar) (Registrar's signature)

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature Philip S. Pendergast (M.D. or other) D.O.
Address Still Wilderth Sanatorium Date signed 3/14/44

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

MOTHER FATHER

1037

(Licensed Embalmer's Statement on Reverse Side)

FEB 20 1944

RECEIVED

District Health Officer No. 10

District File Number 4-44-225

Date Filed APR 8 1944

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 Carland Minor

Licensed Embalmer No. 3414

P. O. Address Mason 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, fact should be so stated above.

Registration District No. 200

Primary Registration District No. 5720

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

1. PLACE OF DEATH:

(a) County Macou
(b) City or town Hudson Jump
(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 9 mo. 5 das (Specify whether years, months or days)

3. (a) PRINT FULL NAME

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 widow

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

7. Birth date of deceased Sept 7 1905
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 1 If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

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

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 17 1944

11469