

FILED SEP 13 1944

Registration District No. 153

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3022

State File No. 27822

Registrar's No. 86

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

1. PLACE OF DEATH:

(a) County Harrison
 (b) City or town Bethany
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Bethany Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community all of life
years, months or days

3. (a) PRINT FULL NAME: Darryl Gene Gardner

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased: July 30 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months 0 Days 0 If less than one day 5 hr. 0 min.

9. Birthplace: Bethany Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business _____

12. Name: Cleo C. Gardner

13. Birthplace: New Hampton Mo.
(City, town, or county) (State or foreign country)

14. Maiden name: Gene Martin

15. Birthplace: Harrison Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Roberta Dalley

(b) Address: Bethany Mo.

17. (a) Burial (b) Date of death: July 31 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Harrison County

18. (a) Signature of funeral director: Joe E. Wheeler

(b) Address: Bethany Mo.

19. (a) Aug. 1 1944 (b) Zola M. Rivers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison
 (c) City or town Bethany
(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 July day 30
 year 1944 hour 6 minute 55 AM

21. I hereby certify that I attended the deceased from July 30, 1944, to July 30, 1944
 that I last saw him alive on July 30, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital malformation of heart.

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: R. P. L. [unclear] M. D. or other _____

Address: Bethany Mo. Date signed: 8-1-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

not

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 Joe E. Wheeler

Licensed Embalmer No. 3512

P. O. Address Bethany 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.