

FILED DEC 18 1944

Registration District No. **317**

Primary Registration District No. **3066**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
619 Clay Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 years  
years, months or days

3. (a) PRINT FULL NAME

ADELAIDE GARDNER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife A. E. L. Gardner

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

7. Birth date of deceased 8 22 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 3 14 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Walker Finley

13. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lavina Wallace

15. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. A. E. L. Gardner

(b) Address 619 Clay Avenue

17. (a) Burial (b) Date thereof 12-7-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mausoleum

18. (a) Signature of funeral director Alexander Sons

(b) Address 6175 Delmar Boulevard

19. (a) DEC 11 1944 (b) E. J. McLaughlin M.D.  
(Date received for recording) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. 619 Clay Avenue  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6  
year 1944 hour 7 minute 30 a. M.

21. I hereby certify that I attended the deceased from Mar. 15, 1940, to Dec 6, 1944;  
that I last saw her alive on Dec. 6, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Degenerative Myocarditis Duration 4 1/2 yrs.

Due to Arterio Sclerosis

Due to Hypertension

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 0  
Signature Hiram L. Liggett (M. D. or other) M.D.  
Address 3720 Washington Blvd Date signed 12/6/44

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

MOTHER FATHER

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**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 jos. E. Mc Culler  
Licensed Embalmer No. 2460  
P. O. Address 6120 Illinois

**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.**