

FILED APR 10 1945

Registration District No. 217

Primary Registration District No. 3045

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

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Charleston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Roxie Gardner
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race Colored 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 0 1860
 (Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Mississippi (City, town, or county) _____ (State or foreign country) 1

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER
 12. Name unknown
 13. Birthplace unknown (City, town, or county) _____ (State or foreign country) 4
 14. Maiden name Halena Monroe
 15. Birthplace Mississippi (City, town, or county) _____ (State or foreign country) 1

16. (a) Informant Archie Harris
 (b) Address Charleston mo 45

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 45
 (Month) (Day) (Year)

(c) Place: burial or cremation Charleston

18. (a) Signature of funeral director Mathie Sewfield

(b) Address 47145 Sikeston Mo

19. (a) _____ (Date received local registrar) (b) Mathie Sewfield (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Mississippi
 (c) City or town Charleston (If outside city or town limits, write "RURAL") 1
 (d) Street No. 2 (If rural, give location) 2
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 3 day 6
 year 45 hour 8 minute PM
 21. I hereby certify that I attended the deceased from 2-28-45 to 3-6-45
 that I last saw her alive on 2-28-45 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration 6 mon
arteriosclerosis 1 yr

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

Major findings:
 Of operations 93d
 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? _____

(Specify type of place) _____
 While at work? _____ (c) Means of injury 0

23. Signature W. A. Singal (M. D. or other) _____
 Address 224 S. Locust St. Charleston Mo District _____

1201

RECEIVED

District Health Office No. 2,

District File Number

445-586

Date Filed

4/14/45

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.....

Wm. Smith

Licensed Embalmer No.....

4371

P. O. Address.....

Sekeston, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 15

Registration District No. 217

Primary Registration District No. 3045

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

1. PLACE OF DEATH:

(a) County Mississippi
 (b) City or town Charleston
(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 _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Roxie Gardner
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex <u>F</u>	5. Color of race <u>B</u>	6. (a) Single, widowed, married, divorced <u>Married</u>
6. (b) Name of husband or wife _____	6. (c) Age of husband or wife if alive _____ years	
7. Birth date of deceased <u>Mar</u> _____ <small>(Month) (Day) (Year)</small>		

8. AGE: Years 85 Months _____ Days _____
(If less than one day _____ min.)

9. Birthplace _____
(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 May year 1945 hour _____ minute _____ M.

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

14064