V. S. No. 2
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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED DEC 7 1945

State File No. 35290

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10309

**1. PLACE OF DEATH:**

(a) County

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

(c) Name of hospital or institution: City Sanitarium (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2yrs. 9 ds. (Specify whether years, months or days)

In this community 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County

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

(d) Street No. ~~1426 Singleton St.~~ (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME WILLIAM GARDNER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Col.

6. (a) Single, widowed, married, divorced Sgl. 0

6. (b) Name of husband or wife

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

7. Birth date of deceased October (Month) 14, (Day) 1890 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 1 | 3 | hr. min. |

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

10. Usual occupation Laborer

11. Industry or business

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

MOTHER
14. Maiden name Lillian Gardner
15. Birthplace not known (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant

(b) Address 5400 Arsenal St.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 11-19-45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutgers

19. (a) NOV 28 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 17 year 1945 hour 6.35 minute P M.

21. I hereby certify that I attended the deceased from July 1st 1st, 1945 to Nov. 17, 1945; that I last saw him alive on Nov. 17, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to Pulmonary Tuberculosis | 3mos. |
| Due to Paresis 1943x | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| 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? (e) Means of injury

23. Signature Cyrus Pachter (M. D. or other)

Address 5400 Arsenal St. Date signed

(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.....

, Licensed Embalmer No.....

P. O. Address.....

**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.**