

No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37862

FILED NOV 28 1945
Registration District No. 205

Primary Registration District No. 4316

State File No. _____

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Macon
(b) City or town New Cambria
(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 24 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town New Cambria
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HENRY M. 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 married
6. (b) Name of husband or wife Clara Gardner 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased August 1 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Minister

11. Industry or business Retired

MOTHER FATHER
12. Name James Gardner
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lenny Bayne
(b) Address Bowling Green, Mo.

17. (a) Burial (b) Date thereof Oct. 28 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green, Mo.

18. (a) Signature of funeral director H. P. Dilleland

(b) Address _____

19. (a) Oct. 26 1945 (b) Albena M. Dilleland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1945 hour 8:30 minute P M.

21. I hereby certify that I attended the deceased from November 19 1944 to Oct 25 1945 that I last saw him alive on Oct 25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Astrodialysis Duration 11 MO

Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy NO
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? _____

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

23. Signature Powell (M. D. or other) _____ Address New Cambria Mo. Date signed Oct 26 1945

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

RECEIVED

District Health Officer No. 10

District File Number 11-45-1650

Date Filed NOV 23 1945

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. 4019

P. O. Address New Columbia, 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.