

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
FILED NOV 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38625**
Registrar's No. **9695**

Registration District No. **318** Primary Registration District No. **1003**

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: St. Mary's Infirmary
(If not in hospital or institution, write street number or location) 11-9, 11-11
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1602 Carr Drive
(If rural, give location) 17 25
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Georgia Gardner

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 11, 1893
(Month) (Day) (Year)

8. AGE: Years 53 Months 4 Days 0 If less than one day hr. min.

9. Birthplace New Madrid Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name _____

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

16. (a) Informant Lucille Wilson

(b) Address 1602 Carr Drive

17. (a) Removal (b) Date thereof 11-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Sikeston, Mo.

18. (a) Signature of funeral director W. J. Smith

(b) Address 104 Pitt St Sikeston Mo

19. (a) NOV 13 1946 (b) J. F. Bredie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11 year 46 hour 7.30 minute P M.

21. I hereby certify that I attended the deceased from Nov. 10 - 46 1946, to Nov. 11 1946, that I last saw her alive on Nov. 11 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Hypertension

Due to _____
Due to _____

Other conditions (Include pregnancy within 5 months of death) 8 3 W

Major findings: Of operations _____

Of autopsy _____

Duration _____
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

Signature W. Young (M. D. or other) _____

Address 5337 Maple Date signed _____

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

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 Fred J. Smith

Licensed Embalmer No. 2428

P. O. Address 124 Petty St. S. Kanto

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.