

FILED AUG 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28851

317

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 3063		Registrar's No. 1989			
1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u>				b. COUNTY <u>Clayton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Elmwood Park</u>		4002			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Elmwood Park Clayton Mo</u>				d. STREET ADDRESS (If rural, give location) <u>Route #2 - Box 417</u>				UA	
3. NAME OF DECEASED (Type or Print) <u>MOLLIE</u>			a. (First)			b. (Middle)			
GARNER			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>8 15 - 50</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 31 - 1897</u>		9. AGE (In years last birthday) <u>52</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas City Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>James Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Henrietta Mat Kear</u>			14. NAME OF HUSBAND OR WIFE <u>Charley Garner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-Renal - Vascular Disease</u>		ANTECEDENT CAUSES						see back	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						DUE TO (b) _____	
II. OTHER SIGNIFICANT CONDITIONS: <u>442X</u>		Conditions contributing to the death but not related to the disease or condition causing death.						DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>none</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>					
22. I hereby certify that I attended the deceased from <u>August 14, 1950</u> , to <u>Aug 15, 1950</u> , that I last saw the deceased alive on <u>Aug 14, 1950</u> , and that death occurred at <u>about 5 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Francis D. Allen M.D.</u>				23b. ADDRESS <u>177 E. Keifhen Webster Ave</u>		23c. DATE SIGNED <u>8-18-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8-19-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis County Mo</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 18 1950 Herbert R. Danke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>AD Richardson 2625 Glasgow</u>							

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

AD Richardson

Licensed Embalmer No. 2928

P. O. Address 2125 Glasgow

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.