

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 17823  
STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 72

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bern</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT a hospital, give location) HOSPITAL OR INSTITUTION <u>St. Barney Hospital</u> Length of stay in lb <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>609 E Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILBER OTIS GARDNER</u> First Middle Last			4. DATE OF DEATH <u>Mar 28-1957</u> Month Day Year
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 21-1889</u>
9. AGE (In years last birthday) <u>67</u> Months <u>5</u> Days <u>7</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>K. M. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Bellaire Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>George Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hathaway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>707-07-6321</u>	
17. INFORMANT <u>Ruth Gardner</u> Address <u>Brookfield Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Memio</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wch</u> <u>1 wch</u> <u>2 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m. <u>—</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. CITY, TOWN, OR LOCATION <u>Brookfield Mo</u>		20g. COUNTY <u>Mo</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>5/10/56</u> to <u>5/28/57</u> and last saw <u>her</u> alive on <u>5/28/57</u> . Death occurred at <u>9</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. W. Bohm M.D.</u>		22b. ADDRESS <u>Brookfield Mo</u>	
22c. DATE SIGNED <u>5/31/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-31-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION (City, town, or county) <u>Brookfield Mo</u> (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>J. H. Blacklock</u> ADDRESS <u>Brookfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5/31/57</u>	
26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>			

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 1957

JUN 9 1957

JUL 5 1957

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.....  
Signature of Student Embalmer

Signed *J. H. Blacklock*

Licensed Embalmer No. *224*  
P. O. Address *Brookfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.