

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1957

57 022514
State File No.

318

1003

5537
Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3704 Gustine Avenue				e. STREET ADDRESS (If rural, give location) 3402 Roger Place			
3. NAME OF DECEASED (Type or Print) a. (First) BESSIE b. (Middle) GARDNER c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 12, 1957				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 28, 1884	
9. AGE (In years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Beauty Parlor		11. BIRTHPLACE (City and State or Foreign Country) Carlinville, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Edward Trover		13b. MOTHER'S MAIDEN NAME Julia Morriss		14. NAME OF HUSBAND OR WIFE William Walter Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 495-26-8250		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Trover Metz, 3704 Gustine Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension present</u> DUE TO (c) <u>SB</u> 331X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic myocarditis present</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6-9-57</u> <u>2-22-57</u> <u>7-17-54</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		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?			
22. I hereby certify that I attended the deceased from <u>7-17-54</u> , 19 <u> </u> , to <u>6-12-57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>6-11-57</u> , 19 <u> </u> , and that death occurred at <u>3:02</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John Flynn BS MD</u>				23b. ADDRESS <u>1715 So 39th St. Louis Mo</u>		23c. DATE SIGNED <u>6-13-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE <u>June 13, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carlinville, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>JUN 14 '57</u>		REGISTRAR'S SIGNATURE <u>Cash Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H., INC., 1936 St. Louis Ave.</u>			

WRITE PLAINLY—USING UNFAADING 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 _____
Signature of Student Embalmer

Signed *Delia J. Kaufman* _____

Licensed Embalmer No. *349*

P. O. Address *St. Louis*

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.