

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4-5464

58-013831

STATE FILE NUMBER

FILED MAY 5 1958

Registration District No. 129

Primary Registration District No. 2000

Registrar's No. 448

300  
1-57  
3

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dead on arrival - Burge Hospital</u>		Length of stay in lb <u>2 years</u>	d. STREET ADDRESS (If outside, give location) <u>316 E. Chestnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Winford Gardner</u>			4. DATE OF DEATH Month Day Year <u>April 26, 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1875</u>
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (City and state or country) <u>Webster County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>R. Don Gardner</u>	
13b. MOTHER'S MAIDEN NAME <u>Larenda Penland</u>		14. NAME OF HUSBAND OR WIFE <u>Lena Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Ebon R. Gardner</u> Address <u>Springfield, 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>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>			<u>4200</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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.)	
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year a.m. <u>  </u> 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1-17-52</u> to <u>4-26-58</u> and last saw him alive on <u>12-27-57</u> Death occurred at <u>2 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>0 M.D.</u>	
22b. ADDRESS <u>609 Cherry-Springfield, Mo.</u>		22c. DATE SIGNED <u>4-28-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 29, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>	23d. LOCATION (City, town, or county) (State) <u>Niangua, Missouri</u>
24. FUNERAL DIRECTOR <u>Burgess - Schepel 7. Home</u> <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>

(Licensed Embalmer's Statement on Reverse Side)

Occasion, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Lewis G. Schaeffer* .....

Licensed Embalmer No. *3802* .....  
P. O. Address *Springfield* .....

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.