

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023944

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1536

300
-57
0

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>ST. LOUIS</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>CLAYTON</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Kinlock 4000 7610</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>Clayton County Hosp.</u> Length of stay in 1b <u>24 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>1618 Monroe St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Gardner</u> Last <u>Gardner</u>			4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>58</u>		
---	--	--	--	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1891</u>	9. AGE (In years last birthday) <u>66</u>	10. FUNDER YEAR Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
-----------------	-----------------------------	---	----------------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Tenn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	--

13a. FATHER'S NAME <u>Henry Gardner</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Dead</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 <u>Robert Gardner</u> Address <u>3136 Cass ave.</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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>491X</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephritis</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.)
20c. TIME OF INJURY Hour <u>2:25 a.</u> Month <u>5</u> Day <u>11</u> Year <u>58</u> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (Specify about home, farm, factory, street, or other place, e.g., etc.)	20f. CITY, TOWN, OR LOCATION <u>601 So. Brentwood</u> COUNTY <u>St. Louis</u> STATE <u>MO</u>
--	--	---

21. I attended the deceased from 5-11-58 to 6-5-58 and last saw her alive on 6-5-58
Death occurred at 2:25 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Angelo A. Spens M.D.</u> (Degree or title)	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>6-5-58</u>
--	---------------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-9-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, MO</u>
---	-------------------------	---	---

24. FUNERAL DIRECTOR <u>Gus Lowe</u> ADDRESS <u>2930 Dickson St.</u>	25. DATE RECD. BY LOCAL REG. <u>6-9-58</u>	26. REGISTRAR'S SIGNATURE <u>Robert P. Danke M.D.</u>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

 *Leroy H. Panminister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Wood*

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.