

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031921

FILED VS OCT 13 1959

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 212

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>5 da.</u>	c. CITY OR TOWN <u>Washington</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>St. Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>432 Cedar St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Rose</u> Last <u>GARDNER</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1959</u>	9. AGE (last birthday) <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Paul Carl Gardner</u>		13b. MOTHER'S MAIDEN NAME <u>Jessie A. Weirich</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>Paul E. Gardner, Washington, Mo.</u> Address	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congenital heart disease, type undetermined.

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO (b) _____

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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> a.m. <u></u> p.m. <u></u> Month, Day, Year <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 1 Oct 59 to 6 Oct 59 and last saw her ^{her} _{him} alive on 6 Oct 59
Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. B. Boyd, MD</u> (Degree or title)	22b. ADDRESS <u>Washington, Mo</u>	22c. DATE SIGNED <u>7 Oct 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct. 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Pius Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>
24. FUNERAL DIRECTOR <u>Theburg & Co., Washington, Mo.</u> <u>L. H. Pitt.</u>		25. DATE RECD. BY LOCAL REG. <u>10/7/59</u>	26. REGISTRAR'S SIGNATURE <u>R. B. Boyd, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jerome T. Levold

Licensed Embalmer No. 4507

P. O. Address Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.