

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037274

FILED VS OCT 27 1959

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 245

1. PLACE OF DEATH a. COUNTY <u>ST CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: * Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST CHARLES</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST LOUIS (14)</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH'S HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2627 BROUSTER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ALSIE</u> Middle <u>GARDNER</u> Last			4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>59</u>			
--	--	--	--	--	--	--

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>6-19-1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
------------------	---------------------------	---	-----------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STREET DEPT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>LACROE GAS CO</u>	11. BIRTHPLACE (City and state or country) <u>CHRISTIAN MO MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	---	--	--

13a. FATHER'S NAME <u>J.H. GARDNER</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN KIMMLER</u>	14. NAME OF HUSBAND OR WIFE <u>PINKIE GARDNER</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>493-05-2347</u>	17. INFORMANT <u>PINKIE GARDNER</u> Address <u>2627 BROUSTER</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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ a.m. _____ p.m. Month, Day, Year _____

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 18 Aug 59 to 18 Oct 59 and last saw her/him alive on 18 Oct 59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. E. Hengen MD</u> (Degree or title)	22b. ADDRESS <u>Bridgeton mo</u>	22c. DATE SIGNED <u>19 Oct 59</u>
--	-------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>	23b. DATE <u>10-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT LEBANON</u>	23d. LOCATION (City, town, or county) (State) <u>STANN Missouri</u>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <u>Earl Hilleman OVERLAND MO</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Oct. 19-59</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 27 1968 27 130 SA

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 Earl B. Coleman

Licensed Embalmer No. 3501

P. O. Address Oreland, Va.

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.