

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 4 1960

=60-035857

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 381

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Francois					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		Length of stay in 1b 5 weeks		c. CITY OR TOWN Desloge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) N Main		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Alexander Middle (None) Last Gardner				4. DATE OF DEATH Month Sept. Day 30th. Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1886 - 73		9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Electrical Mfg.		11. BIRTHPLACE (City and state or country) St. Francois Co. Mo		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Alexander Gardner			13b. MOTHER'S MAIDEN NAME Jane Smith			14. NAME OF DECEASED'S WIFE Jessie 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. 498 10 2379		17. INFORMANT Address Mrs. Jessie Gardner, Desloge, Mo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatous Bronchiogenic Carcinoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 9 MONTHS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 9 MONTHS		
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 Month, Day, Year a.m. p.m.									
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 1-21-60 to 9-30-60 and last saw ^{him} live on 9-30-60 Death occurred at 6:20A on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) W. Paul Dennis M.D.				22b. ADDRESS Flat River Mo			22c. DATE SIGNED 9-30-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/2/1960	23c. NAME OF CEMETERY OR CREMATORY St. Francois Mem. Park		23d. LOCATION (City, town, or county) St. Francois Co. Mo.		(State)		
24. FUNERAL DIRECTOR ADDRESS C.Z. Boyer & Son, Inc. Desloge, Mo				25. DATE RECD. BY LOCAL REG. Sept 30, 1960		26. REGISTRAR'S SIGNATURE Etherell Rudloff			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 7 1960

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



Licensed Embalmer No. 3660

P. O. Address Desloge, Miss

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.