SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 2695 STATE FILE NUMBER -61-010818

FILED MAR 30 1961 318

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis | Length of stay in 1b

c. CITY OR TOWN Saint Louis | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 5594 Etzel Avenue | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Mattie Middle Last Gardner

4. DATE OF DEATH Month March Day 18, Year 1961

5. SEX Female

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 10-5-1881

9. AGE (last birthday) 79 | 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Shannon, Mississippi

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME George Foy

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Lena Gardner Address 5594 Etzel Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Heart. Disease | INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 443x
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 3/1/61 to 3/18/61 and last saw her/him alive on 3/18/61
Death occurred at 7 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carlyle C. Payne MD

22b. ADDRESS 1423 No Grand

22c. DATE SIGNED 3/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Shipped

23b. DATE 3-23-61

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Shannon, Mississippi

24. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral System, Inc. 5010 Enright

25. DATE RECD. BY LOCAL REG. MAR 21 1961

26. REGISTRAR'S SIGNATURE Hal Smith. M.D.

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

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 John R. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marous Ave.

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.