

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-040174

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1193

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>40 years</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph's Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>404 Massachusetts Ave</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Blaine</i> Middle <i>Guy</i> Last <i>Gardner</i>				4. DATE OF DEATH Month <i>November</i> Day <i>20</i> Year <i>1961</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 23, 1884</i>	9. AGE (last birthday) <i>77</i>	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) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mo. Iron & Metal</i>		11. BIRTHPLACE (City and state or country) <i>Fargo, North Dakota</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>Unknown</i>			13b. MOTHER'S MAIDEN NAME <i>Unknown</i>			14. NAME OF HUSBAND OR WIFE <i>Amelia Gardner</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Clifford Gardner 404 Mass. Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yr.</i>	
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 checked="" 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 _____ 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 <i>11-11-61</i> to <i>11-20-61</i> and last saw him alive on <i>11-20-61</i> Death occurred at <i>8:15 A.M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Arthur W. H. Craig M.D.</i>				22b. ADDRESS <i>Social Welfare Board 10th & Olive, St. Joseph, Mo.</i>		22c. DATE SIGNED <i>11-22-61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<i>Burial</i>		<i>Nov. 22, 1961</i>	<i>Mount Auburn Cemetery</i>		<i>St. Joseph, Mo.</i>			
24. FUNERAL DIRECTOR <i>Clark Funeral Home</i>			ADDRESS <i>St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Nov. 24, 1961</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Standell</i>	

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

O.W. J. Craig, M.D. 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 E. A. Cook

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.