

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-037553**

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9538**

**FILE** OOT 1 1963

DO NOT WRITE ON THIS STUB  
 AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>40 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2709 S. 9th</b>		d. STREET ADDRESS (If outside, give location) <b>2709 South 9th St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willard T. Gardner</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>21</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>? Cau.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-1885</b>
9. AGE (last birthday) <b>78</b>		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) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Missouri</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. NAME OF HUSBAND OR WIFE <b>Myrtle Gardner</b>	
13a. FATHER'S NAME <b>Charles Gardner</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[Redacted]</b>	
17. INFORMANT <b>Mrs. Myrtle Gardner</b>		Address <b>2709 S. 9th St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of the prostate with</b>			<b>16 mos.</b>
DUE TO (c) <b>Undescribed Metastases.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>177x</b>			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.			
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 <b>March 1963</b> to <b>Sep 21, 1963</b> and last saw him alive on <b>Sep. 20, 1963</b> Death occurred at <b>655 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Anna Alex MD</b>		22b. ADDRESS <b>3120 Washington Ave</b>	
22c. DATE SIGNED <b>9/23/63</b>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-24-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>McLaughlin</b>		ADDRESS <b>2301 Lafayette Ave.</b>	
25. DATE RECD. BY LOCAL REG. <b>SEP 24 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

**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,

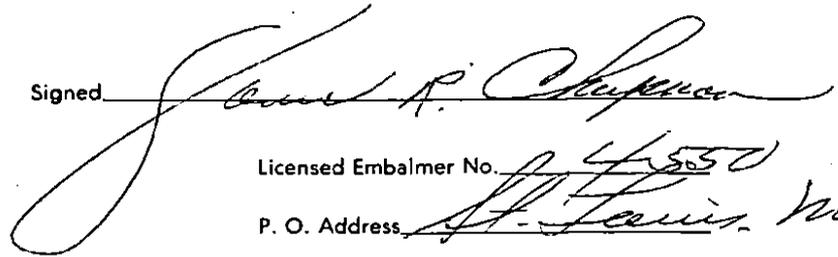
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. \_\_\_\_\_

4550

P. O. Address \_\_\_\_\_

St. Louis, Mo

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.