

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0014906

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2069

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 04/95

3

4 0

5 1

6

7 0

8 0

9 1/93

10

11

12 6/12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Willard B. Young MEDICAL CERTIFICATION

PLACE OF DEATH  
a. COUNTY JACKSONb. CITY (If outside corporate limits, give TOWNSHIP only)  
TOWN KANSAS CITY

Length of stay in 1b

9 Days  
Inside limits  
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION LAKESIDE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MISSOURI b. COUNTY

c. CITY OR TOWN WEBB CITY

Inside Limits  
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)  
611 NO. WEBB STREETReside on Farm  
Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

OSCAR

H.

GARDNER

4. DATE OF DEATH

Month

Day

Year

APRIL

20

1964

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9-10-1891

9. AGE (last birthday)

72

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)

RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

S.W.BELL TELEPHONE

11. BIRTHPLACE (City and state or country)

PINEVILLE, MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

A. M. GARDNER

13b. MOTHER'S MAIDEN NAME

SARAH M. WATKINS

14. NAME OF HUSBAND OR WIFE

ROSA GARDNER

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

NO

NO

16. SOCIAL SECURITY NO.

510-10-7807

17. INFORMANT

Rosa Gardner, 611 No. Webb St. Webb City, 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)

Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATH

5 hr

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

Congestive heart failure

3 1/2 hr

DUE TO (c)

Pneumonia

3 days

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 ☐ Unknown19. 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, Year20d. 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 April 11, 1964, to April 20, 1964 and last saw her alive on April 20, 1964  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

4-21-64

23c. NAME OF CEMETERY OR CREMATORY

PATRIDGE CEMETERY

23d. LOCATION (City, town, or county)

PATRIDGE, KANSAS

(State)

24. FUNERAL DIRECTOR

ADDRESS

GEOC. CARSON &amp; SONS, INDEPENDENCE, MO.

25. DATE RECD. BY LOCAL REG.

4-20-64

26. REGISTRAR'S SIGNATURE

Beaie Smith

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

0000100  
2000

NO. 1000111111

x  
12007 E 47 ST  
M. B. Kessel

**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

*Rollie Kessel*

Licensed Embalmer No.

*4690*

P. O. Address

*Indep. 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.