

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

754

Registrar's No. _____

754

Registration District No. 7911Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____ **REC'D FEB 17 1940**
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 5360 Theodosia 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days) 635

8. (a) PRINT FULL NAME Mary Josephine Gardiner

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife Elbert Gardiner 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased April 28 1874
(Month) (Day) (Year)8. AGE: Years 65 Months 8 Days 25 If less than one day hr. _____ min. _____9. Birthplace Gregory's Landing Mo
(City, town, or county) (State or foreign country)10. Usual occupation Housewife11. Industry or business Home12. Name Michael Doyle13. Birthplace Unknown14. Maiden name Mary Jane Nickol15. Birthplace Unknown

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. R. Gardiner(b) Address 5339 Minerva17. (a) burial (b) Date thereof Jan 26, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Valhalla Cemetery18. (a) Signature of funeral director Drehmann Harral(b) Address 1905 Union Blvd19. (a) JAN 25 1940 (b) J. F. Buddeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis 6
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5360 Theodosia
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23 year 1940 hour 1 minute 40 P. M.21. I hereby certify that I attended the deceased from Jan 12, 1940 to Jan 23, 1940 that I last saw her alive on Jan 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Myo-carditisDue to Cardio-Renal DiseaseDue to Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Manner of injury _____

23. Signature Tom Crompton (M. D. or other) _____Address 601 72 72nd Blvd Date signed 1/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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 this body is not embalmed, above space should be left blank.