

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27275**
3599

FILED AUG 18 1954

BIRTH NO. 74865-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3599

1. PLACE OF DEATH a. COUNTY <u>Childrens Mercy Hospital Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>	
b. CITY OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Mendon</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>3 hours</u>		e. STREET ADDRESS (If rural, give location) <u>R I 0210</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Children's Mercy Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) <u>Mike</u> c. (Last) <u>Gardner</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-23-54</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u>	
8. DATE OF BIRTH <u>July 21, 1954</u>		9. AGE (In years last birthday) <u>7</u>		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR & HRS. <u>7</u> HOURS <u>40</u> MINS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Brookfield, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Vernon Gardner</u>		13b. MOTHER'S MAIDEN NAME <u>Norma Grubbs</u>		14. NAME OF HUSBAND OR WIFE <u>INFANT</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Vernon Gardner</u> ADDRESS <u>Mendon Mo. R#1</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>COR PULMONALE FIBROBLASTOSIS OF THE HEART</u>		INTERVAL BETWEEN ONSET AND DEATH <u>CONGENITAL</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7544	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-22, 1954, to 7-23, 1954, that I last saw the deceased alive on 7-23, 1954, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wayne Hart MD</u> (Degree or title)		23b. ADDRESS <u>1710 Indus Ave. K.C.</u>		23c. DATE SIGNED <u>7-23-54</u>	
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24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-24-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Newgreen Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Mendon Mo.</u>					

DATE REC'D BY LOCAL REG. <u>7-23-54</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Leopold</u> ADDRESS <u>Mendon Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *A. L. Leisner*.....

Licensed Embalmer No. *391*.....

P. O. Address *Mendon*.....

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.