

FILED DEC 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36576**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1250**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (If in place) Life	c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		e. STREET ADDRESS (If rural, give location) 2202 Faraon St.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary C. b. (Middle) Gardner c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) November 29, 1954
---	---

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 6, 1898	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
-------------------------	----------------------------------	--	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	--

13a. FATHER'S NAME John Robert McMachen	13b. MOTHER'S MAIDEN NAME Lillie B. Owen	14. NAME OF HUSBAND OR WIFE Eugene W.
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Eugene W. Gardner, 2202 Faraon, St. Joseph, Mo.	ADDRESS
---	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.		DUE TO (b) Coronary Arteriosclerosis	unk.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

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) (m.)	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 **Nov 26, 1954** to **Nov 29, 1954**, that I last saw the deceased alive on **Nov 29, 1954**, and that death occurred at **4:10 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Martin H. Christ, M.D.	23b. ADDRESS 202 Physicians & Surgeons Bldg.	23c. DATE SIGNED 11-29-54
---	--	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 12/1/1954	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
--	-------------------------------	---	--

DATE REC'D BY LOCAL REG Dec 2, 1954	REGISTRAR'S SIGNATURE Cothran M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Hester Bowman	ADDRESS St. Joseph, Mo.
---	--	--	-----------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 24 1962

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 *James B. Hawkins*.....
Licensed Embalmer No. 453

P. O. Address 319 So 10th St

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.