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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9550

Registration District No. FILED APR 15 1941 3 44

Primary Registration District No. 1002

Registrar's No. 959

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ambassador Hotel /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 65 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. Ambassador Hotel 8
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Arch J. Stewart

3. (b) If veteran, name war No

3. (c) Social Security No. 486-10-1116

4. Sex Male /

5. Color or race white

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Mrs. Carolyn Stewart

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased April (Month) 25, (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
69	10	12	hr. min.

9. Birthplace Bucyrus, (City, town, or county) Ohio / (State or foreign country)

10. Usual occupation Manager Bond Dept.

11. Industry or business American Service Co.

FATHER
12. Name Dr. Robert M. Stewart
13. Birthplace (City, town, or county) Ohio / (State or foreign country)

MOTHER
14. Maiden name Susan Frank
15. Birthplace (City, town, or county) Ohio / (State or foreign country)

16. (a) Informant Mrs. Carolyn Stewart
(b) Address Ambassador Hotel

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-9-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Freeman Morutary
(b) Address 104 West 42nd Street

19. (a) 3/8/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th year 1941 hour ..... minute 8:30 A M.

21. I hereby certify that I attended the deceased from ..... 19.... to ..... 19....;
that I last saw h Deputy Coroner alive on ..... 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Coronary Atherosclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death) 94a

Major findings:
Of operations 94a

Of autopsy

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) 3
Address [signature] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Clarence H Chiles

Licensed Embalmer No. 3473

P. O. Address Kl 760

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.