

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36929**
Registrar's No. **4570**

FILED DEC 4 1944
Registration District No. **147**

Primary Registration District No. **1002**

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

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:
2431-DENVER AVENUE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1**
(Specify whether years, months or days) **30 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**

(c) City or town **KANSAS CITY** **47**
(If outside city or town limits, write "RURAL")

(d) Street No. **2431-DENVER AVENUE**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **N**

3. (a) PRINT FULL NAME **MRS MABEL C STEWART**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MR. FRANK E STEWART**

6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **OCTOBER 24 1887**
(Month) (Day) (Year)

8. AGE: Years **57** Months **0** Days **19** If less than one day **10** hr. **16** min.

9. Birthplace **QUINCY ILLINOIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **CHARLES A. NEWCOME**

13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **KATHRINE STUART**

15. Birthplace **COVINGTON KENTUCKY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank E Stewart**

(b) Address **2431-DENVER AVENUE**

17. (a) **BURIAL** (b) Date thereof **NOV-13-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. MORIAN CEMETERY**

18. (a) Signature of funeral director **D. H. Newcomes Sons**

(b) Address **1401 BRUSH CREEK BLVD.**

19. (a) **11-13-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **10**TH
year **1944** hour **3** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Oct 24**
1944 to **Nov. 9 1944**
that I last saw her alive on **Nov 9 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocardial failure**

Due to **Myocarditis chronic**

Due to **✓**

Other conditions (include pregnancy within 3 months of death) **✓**

Major findings: Of operations **932**

Of autopsy **✓**

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) Means of injury **✓**

23. Signature **Chas H. Proyles** (M. D. or other) **MD**
Address **11222 Professional Bldg** Date signed **11-11-44**

1232 Professional Bldg
11-4-32

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..... *Elmer H. Heston*

Licensed Embalmer No. *1767*

P. O. Address..... *Kansas City*

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, fact should be so stated above.