

FILED APR 8 1949
#85080

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10700

318

1003

Registrar's No. 2907

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2907			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		16			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 3225 Montgomery St., 0					
3. NAME OF DECEASED (Type or Print) EDWARD			a. (First)		b. (Middle) STEWART		c. (Last)		
4. DATE OF DEATH		(Month) (Day) (Year)		Feb. 23, 1949					
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Sept. 15th 1867			
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Robert Stewart			13b. MOTHER'S MAIDEN NAME Anna Ball			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME M. Renard, St. Louis City Hospital				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.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <i>Malnutrition + General Debility</i></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>degeneration of Cerebral Cortex</i></p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>16 x b</i></p>						INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i> <i>10 years</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <i>331X</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 <i>1/22/49</i> , 19____, to <i>2/22/49</i> , 19____, that I last saw the deceased alive on <i>2/22/49</i> , 19____, and that death occurred at <i>8:30 PM</i> m., from the causes and on the date stated above.									
23a. SIGNATURE <i>J. H. Hardin</i>				23b. ADDRESS <i>1515 Lafayette Ave.,</i>		23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <i>MAR 31 1949</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		24d. LOCATION (City, town, or county) _____ (State) _____			
DATE REC'D BY LOCAL REG. <i>MAR 31 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Foxater</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Rowland Mortuary Service</i> ADDRESS <i>4104 Manchester Ave.</i>					

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.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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, fact should be so stated above.