

FILED JUN 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17024

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL Farmington St. Francois</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bonne Terre</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>		d. STREET ADDRESS (If rural, give location) <u>315 South B Street</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CHARLES</u>	b. (Middle) <u>B.</u>	c. (Last) <u>STEWART</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>June 6, 1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 1, 1885</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>11.</u> Days <u>5</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <u>Carpentry for</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Lead Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Bonne Terre, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Martin Light Stewart</u>	13b. MOTHER'S MAIDEN NAME <u>Missouri Washington Sutton</u>	14. NAME OF HUSBAND OR WIFE <u>Grace Pyatt (second wife).</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. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital No. 4, Farmington, Mo.</u>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		<u>At least 6 das.</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Nephrosclerosis</u>		<u>Unknown</u>
	DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>Unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis due to toxemia of nephritis.</u>		<u>446X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from May 31, 1949, to June 6, 1949, that I last saw the deceased alive on June 6, 1949, and that death occurred at 7:00A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John D. Freeman MD</u>	23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	23c. DATE SIGNED <u>6-6-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 9, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bonne Terre</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Mo</u>
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DATE REC'D BY LOCAL REG. <u>June 7, 1949</u>	REGISTRAR'S SIGNATURE <u>Ether R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bentham ...</u>	ADDRESS <u>Bonne Terre Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

RECEIVED

District Health Officer No. 4

District File Number 649-795

Date Filed 6-13-49

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
Student Embalmer

Signed

Charles J. Chynell

Licensed Embalmer No. 5706

P. O. Address Carroll Terrace Md

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.