S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 387

FILED JAN 19 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 38

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

1. PLACE OF DEATH
a. COUNTY Buchanan County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Joseph, Mo
c. LENGTH OF STAY (In this place) 19-6-11
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hosp. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City, Mo - 3118
d. STREET ADDRESS (If rural, give location) Parboe Hotel 1

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) ✓ c. (Last) Stewart

4. DATE OF DEATH (Month) (Day) (Year) January 9. 1953

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 60 years. 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) Character analyst
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kentucky 1
12. CITIZEN OF WHAT COUNTRY? U. S. A

13a. FATHER'S NAME John Stewart
13b. MOTHER'S MAIDEN NAME Helen
14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S SIGNATURE OR NAME State Hospital #2 Records. ADDRESS St. Joseph, Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) 4222

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Dementia praecox, paranoid

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1951, to January 9, 1953, that I last saw the deceased alive on January 9, 1953, and that death occurred at 4 45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Marion Kochanek, V.A.D.
23b. ADDRESS State Hospital #2
23c. DATE SIGNED 1-9-53

24a. ~~BURIAL, CREMATION,~~ REMOVAL (Specify) Removal
24b. DATE Jan. 12/53
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Kirksville, Mo.

DATE REC'D BY LOCAL REG. Jan. 13, 1953
REGISTRAR'S SIGNATURE Carl C. Castel 4-6
25. FUNERAL DIRECTOR'S SIGNATURE Victor Barry ADDRESS St. Jo. Mo.

(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 ..... Student Embalmer No. .....,

working under my personal supervision.

Student ..... Student Embalmer

Signed Victor Barry

Licensed Embalmer No. 42/2

P. O. Address St Joseph Mo

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.