

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14141**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3058**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 4357 Maffitt Ave.		e. STREET ADDRESS (If rural, give location) 4357 Maffitt Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Henry c. (Last) Stewart			4. DATE OF DEATH (Month) (Day) (Year) April 3, 1954
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 3, 1876
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) / Meridian, Miss.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Sam Stewart	13b. MOTHER'S MAIDEN NAME Lucinda DeShields
14. NAME OF HUSBAND OR WIFE Lizzie Stewart		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Ethel Patterson,		ADDRESS 4357a Maffitt	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES DUE TO (b) Hypertensive Cardio-vascular Disease DUE TO (c) ... II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 443X	
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?			
22. I hereby certify that I attended the deceased from Feb 5, 1954 , to Apr 3, 1954 , that I last saw the deceased alive on Apr 2, 1954 and that death occurred at 9 A. M. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS Miss A. Mueller, M. D. 3524 Franklin Ave.	
23c. DATE SIGNED 3/25/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 4-10-54		24c. NAME OF CEMETERY OR CREMATOR St. Louis, Mo. Washington Park Cem. St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. APR 5 1954		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 2625 Glasgow	

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..

Student.....
Signature of Student Embalmer

Signed. *Andrew Richardson*

Licensed Embalmer No. *485*

P. O. Address *2625 Gla*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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