

FILED AUG 17 1954

THE COUNTY OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26452**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **240**

2

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

1. PLACE OF DEATH a. COUNTY Calloway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) Fulton		c. CITY OR TOWN Sedalia	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 13 yrs		e. STREET ADDRESS (If rural, give location) RFD-3 0800	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital no. 1			
3. NAME OF DECEASED a. (First) Owen		b. (Middle) -	
c. (Last) Stuart		4. DATE OF DEATH (Month) (Day) (Year) August 11, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 39 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY none	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME A. T. Stuart		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE none
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. none	17. INFORMANT'S SIGNATURE OR NAME State Hosp #1 Records Fulton Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Staphylococcus Septicemia		DUE TO (b) _____		17 days
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION 0531		21a. ACCIDENT (Specify) SUICIDE		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 <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 June 12, 1939 , to August 11, 1954 , that I last saw the deceased alive on August 11, 1954 , and that death occurred at 2:00 p.m. , from the causes and on the date stated above.		

23a. SIGNATURE (Degree or title) E C Kepler, M.D. by Devera		23b. ADDRESS State Hospital no. 1		23c. DATE SIGNED Aug 11, 1954
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 14, 54	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Sedalia Mo	
DATE REC'D BY LOCAL REG. Aug 12-1954	REGISTRAR'S SIGNATURE Maretha Lawrence	426- L Gillespie	25. FUNERAL DIRECTOR'S SIGNATURE Sedalia	ADDRESS

(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.....
Signature of Student Embalmer

Signed *Russell C. Maag*.....

Licensed Embalmer No...*48*...

P. O. Address *Russell*.....

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.