

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. PARK 30333
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>904</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>DALLAS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>ELKLAND</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>03001</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>OREN</u>			b. (Middle) <u>IRU</u>		c. (Last) <u>STEWART</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 28 1954</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>JAN. 3, 1893</u>		9. AGE (In years last birthday) <u>61</u>	if UNDER 1 YEAR Months Days	if UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>DALLAS COUNTY MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>J. T. STEWART</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET POWELL</u>		14. NAME OF HUSBAND OR WIFE <u>ZOLA STEWART</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W. # 1 ?</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. ZOLA STEWART ELKLAND, MO.</u>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>UREMIA DUE TO CHRONIC GLOMERULONEPHRITIS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>UREMIC PNEUMONITIS AND PERICARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u> <u>2 YRS</u> <u>4 DAYS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>		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) <u>NONE</u>	
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 <u>6-17-52</u> , to <u>9-28</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-28</u> , 1954, and that death occurred at <u>11:50 pm</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>William J. Paul, M.D.</u>				23b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>		23c. DATE SIGNED <u>9/29/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>9/9/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CENTER POINT</u>		24d. LOCATION (City, town, or county) (State) <u>NEAR BUFFALO, MO.</u>		
DATE REC'D BY LOCAL REG. <u>10-1-54</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>			

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

OCT 10 1933

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.....
Gene C. Hunt

Licensed Embalmer No. 475

P. O. Address.....
Springfield

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.