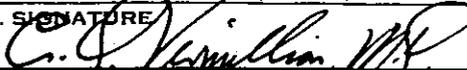
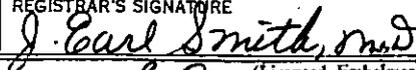


FILED NOV 22 1954

STANDARD CERTIFICATE OF DEATH

State File No. 55203

9831

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Columbia		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				STREET ADDRESS (If rural, give location) 201 First Av 01051			
3. NAME OF DECEASED (Type or Print)		a. (First) Wright		b. (Middle) M		c. (Last) Stewart	
4. DATE OF DEATH		(Month) Oct.		(Day) 28		(Year) 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 31, 1901	
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 18 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Univ Fruit Co		11. BIRTHPLACE (City and State or Foreign Country) Stephens Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME John M Stewart		13b. MOTHER'S MAIDEN NAME Nora Belle Wright		14. NAME OF HUSBAND OR WIFE Mable Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W 2		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mable Stewart Columbia Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Subarachnoid hemorrhage</u>				4 wks.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Aneurysm of left anterior cerebral artery</u>					
		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 checked="" type="checkbox"/> NO <input 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 452X			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1954</u> , to <u>Oct. 28, 1954</u> , that I last saw the deceased alive on <u>Oct. 28, 1954</u> , and that death occurred at <u>12:57 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE  (Degree or title) M. D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 10/28/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-29-54		24c. NAME OF CEMETERY OR CREMATORY Memorial Pk		24d. LOCATION (City, town, or county) (State) Columbia Mo	
DATE REC'D BY LOCAL REG. OCT 29 1954		REGISTRAR'S SIGNATURE 		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington			

(Licensed Embalmer's Statement on Reverse Side)

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

MDV 25 1961

DEC 2 1961

APR 1 0 1961

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 *E. J. Penelick*.....

Licensed Embalmer No. *42*.....

P. O. Address *St. Louis*.....

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.