

FILED MAY 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17038

4130

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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 <b>Park Lane Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>26 2022 North 11th Street</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b> b. (Middle) <b>T.</b> c. (Last) <b>STEWART</b>			4. DATE OF DEATH <b>May 8th, 1955</b> (Month) (Day) (Year)						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 4th, 1893</b>			
9. AGE (In years last birthday) <b>62</b>		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) <b>Store Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Illinois Mo.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>James L. Stewart</b>			13b. MOTHER'S MAIDEN NAME <b>Nina Dollie</b>		14. NAME OF HUSBAND OR WIFE <b>Victoria Stewart</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Raymond E. Stewart</b> ADDRESS <b>2022 North 11th St.</b>				
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, assthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>4 Day</b>	
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input 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? <b>331X</b>				
22. I hereby certify that I attended the deceased from <b>5-8</b> , 1955 to <b>5-8</b> , 1955 that I last saw the deceased alive on <b>5-7</b> , 1955, and that death occurred at <b>4:15 A. m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Clyde R. Kane M.D.</b>				23b. ADDRESS <b>706 Walton</b>		23c. DATE SIGNED <b>5-8-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 11th/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>MAY 10 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leidner Und. Co.</b> ADDRESS <b>2223 St. Louis Ave.,</b>					

(Licensed Embalmer's Statement on Reverse Side)

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 *John S. Penne*.....

Licensed Embalmer No. *414*.....

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.