

FILED DEC 10 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40127

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2619

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Pine Lawn</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Shamrock Rest Home</b>				Length of stay in hospital <b>10 Days</b>		d. STREET ADDRESS (If outside, give location) <b>3638 Flora Blvd.</b>		
3. NAME OF DECEASED (Type or print) First <b>MINERVA</b> Middle <b>A.</b> Last <b>STEWART</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1956</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18, 1887</b>		
9. AGE (In years last birthday) <b>69</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>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Heller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Laurel F. Stewart</b> Address <b>1183 Southworth</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma, ovary</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) :							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>unknown</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE		
21. I attended the deceased from <b>Oct 25, 1956</b> to <b>Nov 3, 1956</b> and last saw her <b>him</b> alive on <b>Oct 29, 1956</b> Death occurred at <b>11:20 A. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Lewes Littmann MD</b>				22b. ADDRESS <b>8231 Clayton Rd (17)</b>			22c. DATE SIGNED <b>11/5/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 5, 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway</b>			25. DATE RECD. BY LOCAL REG. <b>11-5-56</b>		26. REGISTRAR'S SIGNATURE <b>Herbert B. Dornke MD</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

health, welfare, public service

4

Coroner cannot certify to a death due to natural causes. All diseases in Part I must be causally related.

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

MEDICAL CERTIFICATION

87.

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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 *William C. White*.....

Licensed Embalmer No. *42*

P. O. Address *2221 1/2 St. N. W.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.