

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15274

STATE FILE NUMBER

FILED MAY - 8 1957

318

Primary Registration District 1003

Registrar's 3928

Registration District No.

Registrar's

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. James		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b 2 Weeks	d. STREET ADDRESS Star Route (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle GARRETT Last SEWELL			4. DATE OF DEATH Month APRIL Day 23 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1891	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. James, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Sewell			14. MOTHER'S MAIDEN NAME Sarah Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Essie Sewell, Star Route, St. James, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) CHRONIC GLOMERULONEPHRITIS DUE TO (c) 592* PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) THORACIC DUCT CYST					INTERVAL BETWEEN ONSET AND DEATH 10 YRS.
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 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 COUNTY STATE	
21. I attended the deceased from APRIL 5, 1957 to APRIL 23, 1957 and last saw her alive on APR. 23, 1957 Death occurred at 2:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. J. Vanillion M.D.</i> (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 4/23/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-23-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) St. James, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. ADDRESS			25. DATE RECD. BY LOCAL REG. APR 24 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Service

S. 300 y. 1-56

Securing the file. Certification in the special memorial required by 1957-10-10-1957.

MISSOURI
PHYSICIAN
MAY 10 1967

Star Route
St. James, Mo.
2 weeks

1981, 1982
white male

St. James, Mo.
John Jewell

St. James, Mo. Star Route, St. James, Mo. Unknown Yes

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 J. Haine*
Licensed Embalmer No. 4100

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.