

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH38434  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 54E Registrar's No. 2460

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>So. Kinloch 4000</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp.</u>			Length of stay in 1b <u>3 DAY 6</u>		d. STREET ADDRESS (If outside, give location) <u>320 Washington</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Marie</u> Last <u>Stewart</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1957</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1957</u>		9. AGE (In years last birthday) <u>6 wks</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LITTON STEWARD</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA TUCKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>LITTON STEWARD</u>		Address <u>320 Washington</u> <u>So. Kinloch</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of longitudinal sinus and soft sigmoid sinus - Acute Pulmonary Edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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
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 <u>3:30</u> 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 <u>Clayton, Mo.</u>		COUNTY STATE	
21. I attended the deceased from <u>10-3-57</u> to <u>10-6-57</u> and last saw her <u>him</u> alive on <u>10-6-57</u> Death occurred at <u>3:30</u> <u>Am</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Francis J. Scammon MD</u> (Degree or title)				22b. ADDRESS <u>6015 Brentwood, Clayton, Mo.</u>		22c. DATE SIGNED <u>10-6-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 8, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Boyd Bros Funeral Home, Kinloch</u>			25. DATE RECD. BY LOCAL REG. <u>10-6-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert P. Danke MD</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
Services300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

are

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 *Edward A. Flynn*

Licensed Embalmer No. *44*

P. O. Address *Kintoch*

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.