

MAY 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017444

STATE FILE NUMBER

XC-1215259

REG.# 15865

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 374

300

1-57

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All diseases in Part I must be causally related. Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN CORNING 80308
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in lb 9 DAYS	d. STREET ADDRESS (If outside, give location) CORNING NURSING HOME
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH FRANK STEWART			4. DATE OF DEATH Month Day Year MAY 21, 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) SHELBYVILLE, ILLINOIS
13a. FATHER'S NAME WILLIAM O. STEWART		13b. MOTHER'S MAIDEN NAME ANNA L. PERRYMAN	14. NAME OF HUSBAND OR WIFE NOT APPLICABLE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, 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) CHRONIC PYELONEPHRITIS.			INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 6000 F			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. FRACTURED HIP. 2. CEREBRAL THROMBOSIS WITH LEFT HEMIPLEGIA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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. attended the deceased from May 12, 1958 to May 21, 1958 Death occurred at 4:05 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Med. Svc.		22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 5/22/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-22-58	23c. NAME OF CEMETERY OR CREMATORY Frieden's Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Frank-Cotrell Poplar Bluff, Mo.		25. DATE RECD. BY LOCAL REG. 5/24/58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

RECEIVED

MAY 26 1958

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Charles E Mungle

Licensed Embalmer No. 2877
P. O. Address Poplar Bluff

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.