

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033156

STATE FILE NUMBER

FILED SEP 30 1958

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 402

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Independence <u>70050</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 706 N. Union		d. STREET ADDRESS 706 N. Union (If outside, give location)	
3. NAME OF DECEASED (Type or print) MR. ROBERT KENNETH STEWART		4. DATE OF DEATH Sept. 23, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banking		11. BIRTHPLACE (City and state or country) Saginaw, Michigan	
13a. FATHER'S NAME William A. Stewart		14. NAME OF HUSBAND OR WIFE Ida Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Mrs. Ida Stewart	
16. SOCIAL SECURITY NO. 450-01-4012		Address 706 N. Union, Indep., 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) Acute Pulmonary Edema Posterior wall myocardial infarction Hypertensive Cardio Vasc. Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 4201			INTERVAL BETWEEN ONSET AND DEATH 2 days - 3 mos. several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post paralytic - cerebral hemorrhage			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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 May 16-1958 to Sept 22-1958 and last saw her alive on Sept 22-1958 Death occurred at 1:40 A.M. m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Chaet. Hickson J.D.M. (Degree or title)		22b. ADDRESS Independence Mo	
22c. DATE SIGNED 9-23-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 25, 1958	
23c. NAME OF CEMETERY OR CREMATORY Mt. Muncie		23d. LOCATION (City, town, or county) (State) Leavenworth, Ka	
24. FUNERAL DIRECTOR Ott & Mitchell, Indep., Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 9-25-58	
		26. REGISTRAR'S SIGNATURE [Signature]	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

SEP 1 1958

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 

Licensed Embalmer No. 3156

P. O. Address Indy Mo

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.