

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041196

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 134

300
-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		c. CITY OR TOWN Bonne Terre	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital		d. STREET ADDRESS (If outside, give location) 314 S Spruce	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES E. STEWART			4. DATE OF DEATH Month Day Year Nov. 26, 1958
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 July 24, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Coal Dealer		10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (City and state or country) Near Leadwood, Mo.
13a. FATHER'S NAME Martin Stewart		13b. MOTHER'S MAIDEN NAME Missouri Sutton	14. NAME OF HUSBAND OR WIFE Sarah Kidd Stewart
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Address Sarah Stewart Bonne Terre, 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) Coronary thrombosis with myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive vascular disease			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 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 Aug. 1956 to Nov. 26, 1958 and last saw him alive on Nov. 26, 1958 Death occurred at 11:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Maxim J. Haw, J MD		22b. ADDRESS Bonne Terre, Mo.	22c. DATE SIGNED 11/30/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 29 1958	23c. NAME OF CEMETERY OR CREMATORY St. Fran. Mem. Park	23d. LOCATION (City, town, or county) (State) Bonne Terre, Mo.
24. FUNERAL DIRECTOR ADDRESS BOYER & SON Bonne Terre, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 1, 1958	26. REGISTRAR'S SIGNATURE Ether Rudloff

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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Oct. 14, 1920

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 *D. T. Boyer*
3660

Licensed Embalmer No.
P. O. Address Desloge, 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.