

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006838

FILED MAR 13 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 82

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Francis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington-St. Francois Twp.</u> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Charleston, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State # 4 Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Cleveland St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in lb <u>6 Mo.</u>			

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Bell</u> Last <u>Stewart</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1879</u>		9. AGE (In years last birthday) <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>Ky</u>		
13a. FATHER'S NAME <u>Jess. N. Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Hannah Snodgrass</u>		14. NAME OF HUSBAND OR WIFE None <u>Unknown.</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. -	17. INFORMANT <u>Records State Hospital #4 and Frank Stewart Rt. # 2 Charleston, Mo</u>
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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>Coronary Occlusion</u> - - - - - instantaneous.		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Coronary Sclerosis</u> - - - - -		<u>Unknown.</u>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis with cerebral arteriosclerosis.</u>		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 <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
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21. I attended the deceased from July 28, 1958 to Jan. 24, 1959 and last saw ~~her~~ ^{him} alive on Jan. 24, 1959
Death occurred at 6:25 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John A. Brennan, M.D.</u>	22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>	22c. DATE SIGNED <u>1-24-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
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24. FUNERAL DIRECTOR <u>Mc Mickle Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 2, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>
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(Licensed Embellisher's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Alfred McWalter*

Licensed Embalmer No. *4195*

P. O. Address *Alfred McWalter*

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.