

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013563  
STATE FILE NUMBER  
1584

7 FEB APR 20 1959 (Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1584)

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jackson |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Kansas City  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 5805 Holmes St.   |  | Length of stay in 1b<br>48 years  | d. STREET ADDRESS 5805 Holmes Street   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>JESSE W. STEWART  |  |   | 4. DATE OF DEATH<br>Month Day Year<br>March 25 1959  |  |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Aug. 22, 1892  | 9. AGE (In years last birthday)<br>66          | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Projector Operator  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Theatre  | 11. BIRTHPLACE (City and state or country)<br>Osawatomie, Kansas   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |
| 13a. FATHER'S NAME<br>Lincoln Stewart  |  | 13b. MOTHER'S MAIDEN NAME<br>Alzena Thompson  |  | 14. NAME OF HUSBAND OR WIFE<br>Mildred Stewart |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>487-05-9111  | 17. INFORMANT<br>Mildred Stewart, 5805 Holmes St. K.C.<br>Address  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardia Infarction<br>DUE TO (b) Coronary arteriosclerosis<br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.<br>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<br>4201  |
| 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<br>Hour Month, Day, Year<br>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 1959 to Mar. 1959 and last saw him alive on Mar. 19, 1959<br>Death occurred at 3:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |  |   |
| 22a. SIGNATURE<br>John B. Justus M.D. 20 Nichols Pkwy K.C. Mo.   |  | 22b. ADDRESS  |  | 22c. DATE SIGNED<br>Mar 25, '59                |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  | 23b. DATE<br>Mch. 27, 1959   | 23c. NAME OF CEMETERY<br>Mount Moriah Cemetery  | 23d. LOCATION (City, town, or county)<br>Kansas City   | 23e. STATE (State)<br>Missouri                 |   |
| 24. FUNERAL DIRECTOR<br>D.W. Newcomer's Sons, K.C. Missouri  |  | 1331 BRUSH CREEK BEVD<br>STATE RECD. BY LOCAL REG.<br>327-59  | 26. REGISTRAR'S SIGNATURE<br>Irene Minshall  |  |   |

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
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 *Basil P. Hove* .....

Licensed Embalmer No. *4724* .....  
P. O. Address *710* .....

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.