

FILED VS AUG 1 0 1958

149

Primary Registration District No. 1602

Registrar's No.

3553

STATE FILE NUMBER

DED

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 Kansas City		Length of stay in 1b 55 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Riverview Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4615 East 43rd Terrace		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle K. Last Stewart				4. DATE OF DEATH Month July Day 19 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-26-1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Osceola, Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James Decker			13b. MOTHER'S MAIDEN NAME Sarah K. Murray			14. NAME OF HUSBAND OR WIFE DeArmond Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Edward P. Stewart, 4615 E. 43rd Terr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebrovascular arteriosclerosis DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH NO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 July 10, 1959 to July 19, 1959 and last saw ^{her} him alive on July 18, 1959 Death occurred at 1:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Robert F. Goodwin M.D.				22b. ADDRESS 5239 Catalina H.C. Kan				22c. DATE SIGNED 7-20-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-21-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri				
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eyler Funeral Home 20 W. LINWOOD, KCMO				25. DATE RECD. BY LOCAL REG. 7-21-59		26. REGISTRAR'S SIGNATURE DeWitt Marshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Robert F. Goodwin

JAN 12 1960

KS MAY 6 1960 STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Wm H. Gentry

Licensed Embalmer No. 503

P. O. Address K.C. 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.