

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039063

FILED VS. NOV. 23, 1959

042

Primary Registration District No.

1000

Registrar's No. 1130

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 3yrs	c. CITY OR TOWN Wallace Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) General Del Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Alex Middle Frank Last Stewart			4. DATE OF DEATH Month Nov. Day 8 Year 1959		
--	--	--	---	--	--

5. SEX Male	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 Jun. 16, 1873	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	--	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re. Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Carthage Tenn.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	--

13a. FATHER'S NAME Rufus Stewart	13b. MOTHER'S MAIDEN NAME Piline A. Dillian	14. NAME OF HUSBAND OR WIFE deceased
--	---	--

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. none	17. INFORMANT Address Wentlo Stewart, Wallace, Mo
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchial Pneumonia		92h
DUE TO (b) arteriosclerotic heart disease		unk
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of the hip.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Not Known
---	--	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. Oct. 17, 59 p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at son's home	20f. CITY, TOWN, OR LOCATION COUNTY STATE Route 8 St. Joseph Missouri
---	---	--	---

21. I attended the deceased from Oct. 17, 1959 to Nov. 8, 1959 and last saw ^{her} him alive on Nov. 7, 1959 Death occurred at 9:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) Martha Christ M.D.	22b. ADDRESS 6106 King Hill Ave	22c. DATE SIGNED 11/9/59.
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/10/59	23c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Weston Mo
--	------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS John E. Peep St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Nov. 16, 1959	26. REGISTRAR'S SIGNATURE Mrs Clark Goodell
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

