

UR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004112

FILED VS JAN 25 1960

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's 2 270

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>2 Days</b>	c. CITY OR TOWN <b>East St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Peoples Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1710 McCasland Ave.</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLA IDA STEWART</b>			4. DATE OF DEATH Month Day Year <b>January 6, 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Clayton, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Eli Davis</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>Moses Stewart</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Lee Alston</b>	Address <b>Rt 4, Box 399 Memphis, Tennessee</b>
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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) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>10 months (Hist)</b>
DUE TO (c) <b>420.0</b>		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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. Month, Day, Year		

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
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21. I attended the deceased from 12-29-59 to 1-6-60 and last saw her alive on 1-6-60  
Death occurred at Peoples Hospital, St. Louis on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>W. A. Fingal M.D.</b>	22b. ADDRESS <b>1652 Central Ave. E. St. Louis, Ill.</b>	22c. DATE SIGNED <b>1-7-60</b>
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23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/15/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Garden of Memory</b>	23d. LOCATION (City, town, or county) (State) <b>Stokey Township, Illinois</b>
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24. FUNERAL DIRECTOR <b>Meriond Officer</b>	ADDRESS <b>2114 Mo. Ave. E. St. L.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 8 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

**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 Frank Prokoff

Licensed Embalmer No. 4356

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.