

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043391

AMENDED Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 203 STATE FILE NUMBER

FILED NOV 21 1961

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>Sheldon</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>City Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Sheldon</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Price</u> Last <u>Steward</u>	4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1961</u>
--	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and state or country) <u>Cedar Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>US</u>
---	---	--	---------------------------------------

13a. FATHER'S NAME <u>Obe Smith Steward</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Robinson</u>	14. NAME OF HUSBAND OR WIFE <u>Maudie Fields Steward</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Nil</u>	17. INFORMANT Address <u>Receptionist-City Hospital, Nevada, Mo.</u>
---	------------------------------------	--

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>Cerebral Arterio Sclerosis with small cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u> </u>	
	DUE TO (c) <u> </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility.</u>	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 checked="" type="checkbox"/> NO <input 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.) <u>none</u>
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		

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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u>Nevada</u> COUNTY <u>Vernon</u> STATE <u>Mo.</u>
---	--	--

21. I attended the deceased from Oct 21 - 61 to Nov 8 - 61 and last saw ^{her}him alive on Nov 8 - 1961
Death occurred at 8:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. Love</u> (Degree or title) <u> </u>	22b. ADDRESS <u>Nevada, Mo</u>	22c. DATE SIGNED <u>11/11/61</u>
---	--------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 11 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sheldon</u>	23d. LOCATION (City, town, or county) (State) <u>Sheldon Mo</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Beeny Funeral Home Sheldon</u> ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>Nov 15 - 1961</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>
--	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

NOV 29 1961

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 L. Gerald Beem

Licensed Embalmer No. _____

P. O. Address _____

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.