

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005012

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 106

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 3 days	c. CITY OR TOWN Kirkwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 963 Box Elder Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH CLAIRE STEWART			4. DATE OF DEATH Month Day Year January 8, 1962		
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5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 43	9. AGE (last birthday) 43	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collection Consultant	10b. KIND OF BUSINESS OR INDUSTRY Collection Agency	11. BIRTHPLACE (City and state or country) Albany, New York	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Joseph B. Stewart	13b. MOTHER'S MAIDEN NAME Claire Ryan	14. NAME OF HUSBAND OR WIFE Louise Stewart
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Army WWII	17. INFORMANT Address Mrs. Louise Stewart, 963 Box Elder, Kirkwood 22, Mo.
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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) Central nervous system depression with subsequent development of bronchopneumonia DUE TO (b) Overdosage of medication DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Intentional ingestion of overdose of medication
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20c. TIME OF INJURY Hour XXXX p.m. Month, Day, Year 1/5/62	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.) home	20f. CITY, TOWN, OR LOCATION Kirkwood	COUNTY St. Louis	STATE Missouri
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 5:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Raymond H. Hall Coroner	22b. ADDRESS Clayton, Mo.	22c. DATE SIGNED 1/15/62

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE Jan 11, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa, St. Louis	25. DATE RECD. BY LOCAL REG. 1-10-62	26. REGISTRAR'S SIGNATURE John B. Murphy
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DEPARTMENT OF HEALTH
STATE OF MISSOURI

DATE OF DEATH

LOCALITY

CITY

COUNTY

NAME OF DECEASED

INITIALS OF EMBALMER

AGE OF DECEASED

SEX

RACE

&

A

CAUSE OF DEATH

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

OTHER INFORMATION

DATE OF EMBALMING

TIME OF EMBALMING

PLACE OF EMBALMING

BY

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 *John S. Penner*

Licensed Embalmer No. 96940

P. O. Address St. Louis

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.