

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005672

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 185 STATE FILE NUMBER

AMENDED

FILED FEB 19 1962

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		Length of stay in 1b <b>62 years</b>	c. CITY OR TOWN <b>St. Joseph, Missouri</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>612 Locust Street</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>612 Locust Street</b>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>E.</b> Last <b>STEWART</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1962</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>Mar. 22, 1879</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Polk City, Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Lee Stewart</b>	13b. MOTHER'S MAIDEN NAME <b>Isabelle Render</b>	14. NAME OF HUSBAND OR WIFE <b>Ora Stewart</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Granddaughter</b> Address <b>Mrs. Marjorie Kunkle-St. Joseph, Missouri</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>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Ukn.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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
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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 <b>4:00</b> a.m. Month, Day, Year <b>8/15/61</b>		

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 <b>St. Joseph, Missouri</b>	COUNTY <b>Buchanan</b> STATE <b>Missouri</b>
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21. I attended the deceased from **8/15/61** to **2/8/62** and last saw **him** alive on **2/5/62**  
Death occurred at **4:00 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>D. E. Sklenar M.D.</b> (Signer or title)	22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>2/12/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 10, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Missouri</b> (State)
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24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Feb 15, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 SHOULD READ  
 BY AFFIDAVIT OF  
 D. E. SKLENAR, M.D. MEDICAL CERTIFICATION

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**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 Raymond H. Hooy

Licensed Embalmer No. 5147

P. O. Address St Joseph Pl

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.