

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043300

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 92

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 3 1962	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> Length of stay in 1b Years _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 Mi. S.E. Lexington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>Missouri</u> b. COUNTY <u>Lafayette</u> c. CITY OR TOWN <u>Lexington (rural)</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.R. 2 3 mi. south East</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>Charles W. Stewart</u>	
4. DATE OF DEATH Month Day Year <u>November 15 1962</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. BIRTHDAY <u>January 17, 1897</u>
9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>
11. BIRTHPLACE (City and state or country) <u>Lafayette Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George Williams Stewart</u>	13b. MOTHER'S MAIDEN NAME <u>Fannie Lewis Spears</u>
14. NAME OF HUSBAND OR WIFE <u>Joda Hitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____
17. INFORMANT Address <u>Mrs. Joda Stewart Lexington, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Died very suddenly on his tractor on way to field.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Died not fall from tractor</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 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 checked="" 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
21. I attended the deceased from <u>New</u> and last saw her him alive of <u>10 more years</u> Death occurred at <u>approx. 7 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Odesa Mo.</u>
22c. DATE SIGNED <u>11-15-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-17-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lexington, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Vaughn-Walker Lexington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-16-62</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

VS 300 Rev. 4/59
10540
20540

DATE AMENDED

3
4 0
5 1
6
7 0
8 2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

9420.1
12 90-3
13 3-0

JUL 18 1966

DEC 4 1962

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 Paul D. Wilson

Licensed Embalmer No. 5192

P. O. Address Freemington, Mo.

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.