

S. No. 2  
-1245  
5-17-39  
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42056**  
Registrar's No. **3642**

FILED JAN 3 1947  
Registration District No. \_\_\_\_\_

Primary Registration District No. **6076**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution since 9-9-46  
(Specify whether years, months or days)  
In this community 26 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2635 Lucas  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME STEWART, George  
3. (b) If veteran, name war World War I  
3. (c) Social Security No. 487 14 1993

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 30  
year 1946 hour 2:30 minute P. M.  
21. I hereby certify that I attended the deceased from 9-9-46  
to 12-30-46  
that I last saw him alive on 12-30-46  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mrs. Luevenia Stewart  
6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased August 15 1893  
(Month) (Day) (Year)

Immediate cause of death CORONARY ARTERIOSCLEROSIS  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions NONE  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
53 4 15 hr. min.

Major findings: Of operations No Operation  
Of autopsy Autopsy performed (See Cause of Death)  
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) No  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury ①

9. Birthplace Goodman, Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar, Vet. Adm. Hospital.

(b) Address Jefferson Barracks 23, Missouri

17. (a) BURIAL (b) Date thereof 1-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nat. Cem. Home

18. (a) Signature of funeral director W. WADE FUNERAL HOME

(b) Address St. Louis, Missouri

19. (a) 1-4-47 (b) Ruth J. Allen  
(Date received local registrar) (Registrar's signature)

23. Signature L. E. Stimmell (M. D. or other)  
Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 12-30

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
46800

JUL 1 1947.

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *H. Claude Gordon*.....

Licensed Embalmer No..... *3489*.....

P. O. Address..... *4575 Aldine*.....

**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 this body is not embalmed, fact should be so stated above.**