

FILED APR 21 1949
96366

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14206
Registrar's No. 3317

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY <i>Put</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		9	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 2901 HENRIETTA	

3. NAME OF DECEASED (Type or Print) George	a. (First)	b. (Middle)	c. (Last) Stewart	4. DATE OF DEATH (Month) (Day) (Year) 4 13 1949
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY-28-1854	9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) ML	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) TAMIRO ILL	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME WILLIAM STEWART	13b. MOTHER'S MAIDEN NAME HELDRA UNK	14. NAME OF HUSBAND OR WIFE LILLIE MAY RILEY
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME JENNIE FACEY	ADDRESS 2901 HENRIETTA
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Malnutrition		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES In fecal Impaction		
	MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. Anemia, hyperchloremia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2902			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION etc	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-6-49**, 19___, to **4-13-49**, 19___, that I last saw the deceased alive on **4-13-49**, 19___, and that death occurred at **1:20 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) MD	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 4-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE APR-13-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) CAIRO, ILL.
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DATE REC'D BY LOCAL REG. APR 13 1949	REGISTRAR'S SIGNATURE J B Casater	25. FUNERAL DIRECTOR'S SIGNATURE E. J. SCHNUR	ADDRESS 305 LAFAYETTE
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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
Student Embalmer

Signed *Justo Volmer*

Licensed Embalmer No. *4814*

P. O. Address *2125 Lafayette*

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.