

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 5 1951

State File No. **18643**

BIRTH NO. **33654-51** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4834**

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 — <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>2129</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		e. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Brenda</b> b. (Middle) <b>Faye</b> c. (Last) <b>Stewart</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>5 14 51</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>0</b>	8. DATE OF BIRTH <b>5-13-51</b>
9. AGE (In years last birthday) <b>6</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Missouri 0</b>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <b>James Stewart</b>	13b. MOTHER'S MAIDEN NAME <b>Naomi Syas</b>	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME. ADDRESS <b>Kathryn M. Sheward, R.R. 2, 2601 N. Whittier St.</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DUE TO (b) <b>None</b> DUE TO (c) <b>None</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	
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? <b>776x</b>	
22. I hereby certify that I attended the deceased from <b>5-13-</b> , 19 <b>51</b> , to <b>5-14-</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>5-14-</b> , 19 <b>51</b> , and that death occurred at <b>6:15a m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>W. S. Scribner M.D.</b>	23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>5-16-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>MAY 24 1951</b>	24c. NAME OF CEMETERY, OR CREMATORY <b>Anatomical Board</b>	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <b>MAY 24 1951</b>	REGISTRAR'S SIGNATURE <b>J. B. Foster</b>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Rowland Mortuary Service Inc. St. Louis 10, Mo.</b>	

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.