

FILED SEP 17 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30021**

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 786

0396

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Rural Campbell Township	
c. LENGTH OF STAY (in this place) 1 month		d. STREET ADDRESS (If rural, give location) Route 8, Springfield,	
d. FULL NAME OF HOSPITAL OR INSTITUTION 948 St Louis			
3. NAME OF DECEASED (Type or Print) a. (First) CHARLEY		b. (Middle) B	
c. (Last) STEWART		4. DATE OF DEATH (Month) (Day) (Year) Sept 11 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 25, 1874
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY General Farming
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME J R Stewart		13b. MOTHER'S MAIDEN NAME Margaret M Houser	
14. NAME OF HUSBAND OR WIFE Mrs Millie Stewart			
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. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Mrs Millie Stewart, Springfield, Mo.		ADDRESS	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myo Carditis Chronic INTERVAL BETWEEN ONSET AND DEATH Several months ANTECEDENT CAUSES Arteriosclerosis DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Bronchitis Chronic	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221	
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) Springfield Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1951 , to Sept 11, 1951 , that I last saw the deceased alive on Sept 1, 1951 , and that death occurred at 3:20 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. Newton Wakeman M.D.		23b. ADDRESS Springfield Mo.	
23c. DATE SIGNED 9-13-51			
24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept 15, 1951	
24c. NAME OF CEMETERY OR CREMATORY Glidewell Cemetery		24d. LOCATION (City, town, or county) (State) Near Springfield, Missouri	
DATE REC'D BY LOCAL REG. 9-13-51		REGISTRAR'S SIGNATURE W.E. Haudley M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmejer		ADDRESS Springfield Mo.	

Dr. Walter
Woodruff

RECEIVED
MAY 10 1933

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Bernard F. Wright

Signed.....
Student Embalmer

Licensed Embalmer No. 4293

P. O. Address Springfield, 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 this body is not embalmed, fact should be so stated above.