

No. 500  
10-48

XC 13 928 052  
Reg. 98370

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11580

State File No. ....

747

BIRTH NO. FILED MAR 29 1952 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. ....

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP.		d. STREET ADDRESS (If rural, give location) 3038 DICKSON	

3. NAME OF DECEASED (Type or Print) a. (First) BULUS	b. (Middle)	c. (Last) STEWARD	4. DATE OF DEATH (Month) (Day) (Year) 3/15/52
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5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10/12/23	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Camden, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Bill Steward	13b. MOTHER'S MAIDEN NAME Emma Taylor	14. NAME OF HUSBAND OR WIFE Gertrude Steward
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 428-29-3028	17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES CHRONIC GLOMERULONEPHRITIS		
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) - - - - - DUE TO (c) - - - - -		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE	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) VA	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 11/27 19 51, to 3/15, 19 52, that I last saw the deceased on 3/15/52, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title) M.D.	23b. ADDRESS V.A. HOSPITAL JEFF. BRKS: MO.	23c. DATE SIGNED 3/15/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/21/52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Canton, Mississippi
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DATE REC'D BY LOCAL REG. 3-20-52	REGISTRAR'S SIGNATURE Herbert R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue	ADDRESS
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STATEMENT BY LICENSED EMBALMER

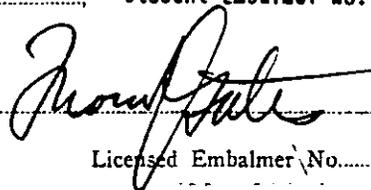
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.