

5. No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16674

R.# 110291

FILED MAY 9 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1221

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 ILLINOIS b. COUNTY PIKE	
b. CITY (If outside corporate limits, write RURAL and give township) JEFFERSON BARRACKS, MO.		c. LENGTH OF STAY (In this place) 2 DAYS	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		c. CITY (If outside corporate limits, write RURAL and give township) CHAMBERSBURG	
		d. STREET ADDRESS (If rural, give location) R.R.# 1	
3. NAME OF DECEASED (Type or Print) a. (First) HOMER		b. (Middle) STEWART	
c. (Last) STEWART		4. DATE OF DEATH (Month) (Day) (Year) 4-29-53	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 4-30-91
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and State or Foreign Country) CHAMBERSBURG, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME DANNY STEWART	
13b. MOTHER'S MAIDEN NAME NELLIE HAM		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BRKS, 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) GUN SHOT WOUND OF HEAD	
		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTecedent causes Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION - 976X -	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) At home on farm	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Chambersburg Pike - Illinois		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) April 27 1953 5:00 PM	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? SHOT SELF WITH 22 CAL. RIFLE	
22. I hereby certify that I attended the deceased from 4-27-53 to 4-29-53 , 19 XXXXXX , and that death occurred at 2:00 P m., from the causes and on the date stated above.			
23a. SIGNATURE Herluf G. Lund		23b. ADDRESS VA HOSPITAL, JEFF. BKS, MO.	
23c. DATE SIGNED 4/29/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-30-53	
24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Versailles, Ill.	
DATE REC'D BY LOCAL REG. 4-30-53		REGISTRAR'S SIGNATURE Herbert R. Domb-M.D	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	

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 Fred J. Farmer

Licensed Embalmer No. 4788

P. O. Address St. Louis 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.