

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39298**

FILED DEC 2-1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5379

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (In this place) <u>77 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>	d. Residence within limits of city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Westport Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>331 North Quincy</u> <u>3068</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ARTHUR</u> b. (Middle) <u>EVERETT</u> c. (Last) <u>STEWART</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov-12-1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 8-1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Boiler Makers</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Newberg, New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Stewart</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Delia Stewart</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y or N or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	INFORMANT'S SIGNATURE OR NAME <u>Delia Stewart</u>	ADDRESS <u>331 North Quincy</u> <u>K.C., Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left Cerebral Hemorrhage</u>		<u>3 days</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Rt Hemiplegia</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>3 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.			<u>331X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	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) (Min.) _____	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 4-24, 1951, to 12 Nov, 1953, that I last saw the deceased alive on 11/Nov, 1953, and that death occurred at 8:45 P.m., from the causes and on the date stated above.

23. SIGNATURE <u>James W. Downey</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>800 Angell Blvd, K.C. Mo.</u>	23c. DATE SIGNED <u>11-13-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 14-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>11-13-53</u>	REGISTRAR'S SIGNATURE <u>Sheldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C.H. Blackman & Son Inc.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *W.C. Rinne*.....

Licensed Embalmer No. *4879*.....

P. O. Address *N.C. Ma...*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.