

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

44038

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11947	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.				e. STREET ADDRESS (If rural, give location) 94 3159 Nebraska Ave. 22490			
3. NAME OF DECEASED (Type or Print) a. (First) CATHERINE b. (Middle) _____ c. (Last) (KELLY) STEWART			4. DATE OF DEATH (Month) (Day) (Year) Dec. 30 1954				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 25, 1878	9. AGE (In years last birthday) 76	F UNDER 1 YEAR Months _____	F UNDER 1 YEAR Days _____	F UNDER 1 HR. Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Michael Dwyer			13b. MOTHER'S MAIDEN NAME Margaret McGrath		14. NAME OF HUSBAND OR WIFE Late Robert R. 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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie V. Higgins 3159 Nebraska St.			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Cardiac Hypertrophy II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 17 days 3-5 yrs 3-5 yrs 48	
19a. DATE OF OPERATION _____		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) 443x			
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? _____			
22. I hereby certify that I attended the deceased from <u>June 1954</u> , to <u>Dec 30, 1954</u> , that I last saw the deceased alive on <u>Dec 30, 1954</u> , and that death occurred at <u>3:20A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) E. W. Davis M.D.			23b. ADDRESS 3720 Washington Ave St. Louis Mo			23c. DATE SIGNED 12/31/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan. 3, 1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
DATE REC'D BY LOCAL REG. DEC 31 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			

E.P. (Licensed Embalmer's Statement on Reverse Side)

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 *William R. White*.....

Licensed Embalmer No. *4229*

P. O. Address *4229 St. Louis*

**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.**