

FILED FEB 9 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1693**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **2040** Registrar's No. **42-**

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chillicothe</b>		c. CITY OR TOWN <b>Chillicothe</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>3 days</b>		e. STREET ADDRESS (If rural, give location) <b>207 Asher St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>ALBERTA</b> b. (Middle) <b>STEWART</b> c. (Last) <b>STEWART</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 27 1955</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 16, 1920</b>	9. AGE (In years last birthday) <b>34</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Triplett, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Lem Cooper</b>	13b. MOTHER'S MAIDEN NAME <b>Verlena Bowman</b>	14. NAME OF HUSBAND OR WIFE <b>George W. Stewart</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>George W. Stewart</b> ADDRESS <b>207 Asher St Chillicothe, Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral anoxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
	ANTECEDENT CAUSES <b>Cardiac Arrest of 8 minute duration</b>		
	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 <b>Jan 27, 1955</b>	19b. MAJOR FINDINGS OF OPERATION <b>No gross pathology</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **July**, 19**53**, to **Jan 27**, 19**55**, that I last saw the deceased alive on **Jan 27**, 19**55**, and that death occurred at **10:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>William L. Fair, M.D.</b> (Degree or title)	23b. ADDRESS <b>Chillicothe, Mo.</b>	23c. DATE SIGNED <b>1/31/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-30-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>North Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Chillicothe (Liv. Co.) Mo.</b>
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DATE REC'D BY LOCAL REG. <b>1-31-55</b>	REGISTRAR'S SIGNATURE <b>Franco B. Neill</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>NORMAN FUNERAL HOME</b> ADDRESS <b>Chillicothe, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *Joseph M. Gibson*  
Licensed Embalmer No. *476*  
P. O. Address *Chillicothe*

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.