No. 300
10.48

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20427

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5182

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3811a Maffitt Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural, give location): 3811a Maffitt Ave. 2117 D

3. NAME OF DECEASED (Type or Print)
a. (First): Margaurite
b. (Middle): A.
c. (Last): Stewart

4. DATE OF DEATH (Month) (Day) (Year): June 13 1955

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Aug. 2 1873
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
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. Charles Mo.
12. CITIZEN OF WHAT COUNTRY?:
13a. FATHER'S NAME: John Stewart
13b. MOTHER'S MAIDEN NAME: Anna Grace
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):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Margaret Saale
ADDRESS: 3811a Maffitt Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Senile

ANTECEDENT CAUSES

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.

INTERVAL BETWEEN ONSET AND DEATH: 24 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 4500

22. *I hereby certify that I attended the deceased from* June 13, 1955, *to* June 13, 1955, *that I last saw the deceased alive on* June 13, 1955, *and that death occurred at* 6:30 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Thomas Miller MD
23b. ADDRESS: 4110 N Florissant
23c. DATE SIGNED: 6/14/55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/16/55
24c. NAME OF CEMETERY OR CREMATORY: Calvary
24d. LOCATION (City, town, or county) (State): St. Louis Mo.

DATE REC'D BY LOCAL REG.: JUN 15 1955
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: Sullivan's
ADDRESS: 2849 No. Euclid Ave.

(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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 30

P. O. Address St Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.