

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12117

State File No.

S. No. 300
IV. 10.48

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 164

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write full name and give township) <u>Columbia</u>		c. CITY OR TOWN <u>Sweet Springs</u>	
c. LENGTH OF STAY (In this place) <u>12 hrs.</u>		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 <u>University Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>115 WALNUT</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Keser</u> b. (Middle) <u>Vanda</u> c. (Last) <u>STEWART</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 8 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married Widow</u>	8. DATE OF BIRTH <u>10-25-1905</u>
9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 1 YEAR Days <u>13</u>	IF UNDER 1 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>R.H. Stanley</u>	13b. MOTHER'S MAIDEN NAME <u>Cosby Mullins</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Stewart (Dec)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Bill Campbell Roomville Mo</u>	
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.			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarct</u>			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u></u>			
DUE TO (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>fracture rt. hip 4201F</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SLUGGHE HOMICIDE (Specify) <u>fall</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Sweet Springs Saline Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>5/8 1957</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>patient slipped and fell</u>	
22. I hereby certify that I attended the deceased from <u>5/7 1957</u> , to <u>5/8 1957</u> , that I last saw the deceased alive on <u>5/8 1957</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William H. Wade M.D.</u>		23b. ADDRESS <u>U. of Mo. Hosp, Columbia, Mo.</u>	23c. DATE SIGNED <u>5/8/57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 10/1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u>
DATE REC'D BY LOCAL REG. <u>May 19, 1957</u>	REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Goodman Ball Roomville</u>	

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 *A. F. Boller*

Licensed Embalmer No. *3067*

P. O. Address *Boonville*

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.