

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009107

STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY <b>CALLAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>FULTON</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>POPLAR BLUFF</b> <u>0128</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. HOSPITAL #1</b>		Length of stay in lb <b>3 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>R.F.D. #3</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b></b> Last <b>STEWART</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1958</b>
5. SEX <b>FEMALE</b> <u>3</u>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unk.</b>
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	11. BIRTHPLACE (City and state or country) <b>MISSISSIPPI</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>UNK.</b>	
14. MOTHER'S MAIDEN NAME <b>SALLY ROBERTS</b>		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>UNK.</b>		17. INFORMANT Address <b>ST. HOSPITAL #1, FULTON, MISSOURI</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DECUBITAL ULCERS</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>334X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME DUE TO CEREBRAL ARTERIOSCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>March 30, 1955</u> to <u>March 12, 58</u> and last saw her/him alive on <u>3-12-58</u> Death occurred at <u>5:25 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Erwin Leonhardt, M.D.</i>		22b. ADDRESS <b>Fulton, Mo. St. Hospital No. 1</b>	22c. DATE SIGNED <b>3-12-58</b>
23a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>	23b. DATE <b>3/12/58</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>POPLAR BLOFF MO</b>
24. FUNERAL DIRECTOR <i>Manigie Funeral Home Fulton Mo</i>		25. DATE RECD. BY LOCAL REG. <b>March 14-1958</b>	26. REGISTRAR'S SIGNATURE <i>Martha Lawrence</i>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
300-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of infectious diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....  
*J. J. Rossor*

Licensed Embalmer No. *211*

P. O. Address *Fuller*

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