

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041182

STATE FILE NUMBER

FILED NOV 18 1958

Registration District No. 314 Primary Registration District No. 4458 Registrar's No. 43

300
1-57

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Collins		c. CITY OR TOWN Collins	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 0730	
3. NAME OF DECEASED (Type or print) First Clarence Middle O. Last Stewart		4. DATE OF DEATH Month Oct ; Day 17 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb; 8, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78
11. BIRTHPLACE (City and state or country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Hiram Stewart		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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. None	17. INFORMANT Address Howard Stewart Milwaukee Wis;
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Jan 1, 1955 to Oct 14, 1958 and last saw him alive on Sept 10, 1958 Death occurred at 11:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) H. E. D. Brown DO²		22b. ADDRESS Collins Missouri	22c. DATE SIGNED 10/21/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/21/58	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City, town, or county) (State) Collins Missouri
24. FUNERAL DIRECTOR ADDRESS Goodrich Funeral Home, Osceola Mo;		25. DATE RECD. BY LOCAL REG. 11-6-58	26. REGISTRAR'S SIGNATURE Ruth Seavers

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Deaths, lotions, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

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 B Goodrich*

Licensed Embalmer No. *3038*
P. O. Address *Osceola*

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.