

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043249

STATE FILE NUMBER

FILED DEC 22 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 558

300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Boone County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY <i>CALLAWAY</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Fulton</i> 0140
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>U. medical center</i>		Length of stay in 1b <i>3 days</i>	d. STREET ADDRESS (If outside, give location) <i>ROUTE # 5</i>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>HARRY</i> Middle <i>Alexander</i> Last <i>STEWART</i>			4. DATE OF DEATH Month <i>Dec</i> Day <i>15</i> Year <i>1958</i>		
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5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-14-1904</i>	9. AGE (In years last birthday) <i>54</i>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Director</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>FUNERAL DIRECTOR</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>Geo. W. Stewart</i>	13b. MOTHER'S MAIDEN NAME <i>Mary Onobundes</i>	14. NAME OF HUSBAND OR WIFE <i>Helen M Stewart</i>
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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) <i>No</i>	16. SOCIAL SECURITY NO. <i>488-01-3212</i>	17. INFORMANT <i>Helen Stewart</i>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive right cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>less 1 day</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Epidermoid Carcinoma of pharynx</i>		<i>4 years</i>
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from *12/12/58* to *12/15* and last saw her alive on *12/15/58*  
Death occurred at *7:45 AM* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Earl J. Wiffle, Jr. M.D.</i>	22b. ADDRESS <i>U. of Missouri Medical Center</i>	22c. DATE SIGNED <i>12/15/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Dec. 15, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Gardens</i>	23d. LOCATION (City, town, or county) (State) <i>FULTON, MISSOURI</i>
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24. FUNERAL DIRECTOR <i>MAUPIN FUNERAL HOME, FULTON, MO.</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Dec 15 1958</i>	26. REGISTRAR'S SIGNATURE <i>Mrs R E Palmer</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MAY 26 1959

APR 27 1959

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 *George A. Kerby* .....

Licensed Embalmer No. *4752* .....

P. O. Address *Columbia, W.* .....

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.