

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014539  
State File No.

No. 300  
10-48

FILED APR 20 1959

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>99</u>	
1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Charles</u>		c. LENGTH OF STAY (In this place) <u>1 WK</u>		c. CITY OR TOWN <u>St Charles</u> <u>0920</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Rural Rt 2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arthur</u>		b. (Middle) <u>E</u>		c. (Last) <u>Stewart</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17 1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 1 1884</u>	
9. AGE (In years last birthday) <u>74</u>		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) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sandoval Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Edmund Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Carlson</u>		14. NAME OF HUSBAND OR WIFE <u>Honrietta M. Stewart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-09-0045</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Honrietta M Stewart St Charles 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Metastatic Carcinoma to lung</u> DUE TO (c) <u>Carcinoma of Colon</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yr</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>1538</u>				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in apt, about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12, 1959</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>W H Poggenmies M.D.</u>				23b. ADDRESS <u>St Charles, Mo</u>		23c. DATE SIGNED <u>April 17, 1959</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/18/59</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>APR. 17-59</u>		REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur C Paue St Charles Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 24 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.....  
*David P. Bane*

Licensed Embalmer No. *506*

P. O. Address *St. Clair*

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.