RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ILED VS MAY 31 1960

=60=021818

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1477

1. PLACE OF DEATH a. COUNTY: St Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo b. COUNTY: St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton — Length of stay in 1b: 2 Days	c. CITY OR TOWN: Normandy — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): County Hospital — Inside Limits: Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location): 8505 Geiger — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Agnes Middle: Emma Last: Stewart

4. DATE OF DEATH: Month: May Day: 5, Year: 1960

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
FEMALE	WHITE		1/23/85	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
House work	Home Maker	McLeansboro Ill	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
MAURICE CAMPBELL	SUSAN HAGGARTY	CARTER STEWART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		NONE	NORA HINTON 8505 GEIGER Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MALNUTRITION — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): ADENOCARCINOMA Esophageal-Gastric 1 year.

DUE TO (c): JUNCTION & PROBABLE ORIGEN IN Stomach

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 3, 1960, to May 5, 1960 and last saw her/him alive on May 5, 1960

Death occurred at 12 05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Ronald C Passmore MD	601 S. Brentwood Bl. Clayton	5/5/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	5/6/60	St CLEMENS CEMETRY	McLEANSBORO ILL.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Cullen-Kelly	7267 Natural Bridge	5-5-60	John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed James A. Lamm

Licensed Embalmer No. 414

P. O. Address [illegible]

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