RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 19 1960

-60-028833
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6848

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital, D.O.A.
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Louis
c. CITY OR TOWN: Overland
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 10519 Thorpe Ave.
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: James Middle: B. Last: Stewart
4. DATE OF DEATH: Month: July Day: 5, Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 3/7/1901
9. AGE (last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver
10b. KIND OF BUSINESS OR INDUSTRY: Suburban Cab Co.
11. BIRTHPLACE (City and state or country): Winchester, Ky.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Unavailable Stewart
13b. MOTHER'S MAIDEN NAME: Unavailable
14. NAME OF HUSBAND OR WIFE: Mary F.Stewart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494-09-2134
17. INFORMANT: Mary F.Stewart, Address: 10519 Thorpe Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident, suspected
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 331+
INTERVAL BETWEEN ONSET AND DEATH
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 [X]
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 4/1/60 to 6/25/60 and last saw him alive on 6/25/60
Death occurred at 10:30 pm 7/5/60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Kenneth M. Jentsch M.D.
22b. ADDRESS: Jewish Hospital
22c. DATE SIGNED: JUL 7 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-8-60
23c. NAME OF CEMETERY OR CREMATORY: Bethany Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: JUL 7 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed B W Wilkins

Signature of Student Embalmer

Licensed Embalmer No. 357

P. O. Address M Louis

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