

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038973

FILED VS

Registration District No. 195

Primary Registration District No.

Registrar's No. 84-60

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<i>McDONALD</i>	a. STATE	<i>Missouri</i> COUNTY <i>McDONALD</i>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<i>BUFFALO</i>	c. CITY OR TOWN	<i>Anderson</i>
Length of stay in 1b	<i>13 Years</i>	Inside Limits	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	<i>Route 1 FoodMAN</i>	d. STREET ADDRESS (If outside, give location)	<i>Route 3</i>
Inside Limits	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
<i>HEMAN CHARLES STEWART</i>			<i>Oct.</i>	<i>12</i>
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)
<i>MALE</i>	<i>WHITE</i>		<i>12-8-1885</i>	<i>75</i>
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	
<i>Retired Farmer</i>	<i>FARMING</i>	<i>Follen-ton, Neb</i>	<i>U.S.A.</i>	
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
<i>HEMAN B. STEWART</i>	<i>MARIA CLITS</i>		<i>ETHEL D. STEWART</i>	
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		
<i>No</i>		<i>ETHEL STEWART Anderson, Mo</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Chronic Myocarditis</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<i>Cardiac De-compensation</i>	
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)		PART III. If deceased was female was there a pregnancy in last 90 days.
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. Month, Day, Year		
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

21. I attended the deceased from *6-1-56* to *Oct. 12, 1960* and last saw him alive on *7-8-60*
 Death occurred at *7:15 P.* 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
<i>G.W. Blankenship M.D.</i>	<i>Neosho, Missouri</i>	<i>10-13-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<i>Removal</i>	<i>10-13-1960</i>	<i>Middle Cemetery</i>
23d. LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.
<i>MITCHELL Neb</i>	<i>Keller Funeral Home</i>	<i>Oct. 13, 1960</i>
26. REGISTRAR'S SIGNATURE	26. REGISTRAR'S SIGNATURE	
<i>Jean Sweet Anstatt</i>	<i>G.W. Blankenship, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

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 _____
Signature of Student Embalmer

Signed

Robert C. Koller

Licensed Embalmer No. 57062

P. O. Address Anderson

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.