

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045913

STATE FILE NUMBER

Registration District No. 296

Primary Registration District No. 6018

Registrar's No. 24

AMENDED

FILED DEC 19 1961

1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fishing River</u>		Length of stay in 1b		c. CITY OR TOWN <u>Lawson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Near Elkhorn</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>6 mi N.E. of Lawson</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE HERMAN STEWART</u>				4. DATE OF DEATH Month Day Year <u>Dec 14 1961</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10, 1893</u>		9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sowa</u>				11. BIRTHPLACE (City and state or country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>									
13a. FATHER'S NAME <u>Mahlan Stewart</u>				13b. MOTHER'S MAIDEN NAME <u>Lottie Trader</u>				14. NAME OF HUSBAND OR WIFE <u>Ethel 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>487-07-8397</u>		17. INFORMANT <u>Ethel Stewart</u>		Address <u>Lawson Mo</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hrs</u>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pneumothorax Rt. Spontaneous</u>										<u>3-4 hrs.</u>									
DUE TO (c) <u>Bronchiectasis & Pulmonary fibrosis</u>										<u>YEARS</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Heart Failure, Avitaminosis, Debility</u>										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 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.) <u>J</u>															
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 <u>9-29-61</u> to <u>12-14-61</u> and last saw ^{her} _(him) alive on <u>12-14-61</u> Death occurred at <u>Approx 1:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>A. P. Smith D.D.</u>				22b. ADDRESS <u>Lawson, Mo</u>				22c. DATE SIGNED <u>12-15-61</u>											
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 17, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>											
24. FUNERAL DIRECTOR <u>Jarman Funeral Home Lawson Mo</u>				25. DATE RECD. BY LOCAL REG. <u>12-16-1961</u>		26. REGISTRAR'S SIGNATURE <u>Helen J. Larkin</u>													

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Ludice Jarman

Licensed Embalmer No.

4589

P. O. Address

Excelsior Springs, Mo.

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.