

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041309

STATE FILE NUMBER

Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 27

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 13 1962		
1. PLACE OF DEATH		
a. COUNTY <u>Stoddard</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pike Township</u> Length of stay in lb <u>12 Years</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bell City, Rt. 1</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>		
c. CITY OR TOWN <u>Bell City, Rt 1</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. STREET ADDRESS (If outside, give location) <u>Bell City, Rt 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last		
<u>Wiley Green Stewart</u>		
4. DATE OF DEATH Month Day Year		
<u>Oct 20, 1962</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>8/30/1873</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Month Day IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (City and state or country) <u>Bell City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Alexander Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Patsie Palmer</u>
14. NAME OF HUSBAND OR WIFE <u>Clara 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>None</u>
17. INFORMANT <u>Mrs John Talley Bell City, Mo</u>		Address
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>Malnutrition with Dehydration and Pneumonia 2 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral vascular Thrombosis</u>		<u>3 month</u>
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 <u>10/12/61</u> to <u>10/20/62</u> and last saw him alive on <u>9/19/62</u> . Death occurred at <u>10:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Kenneth D. Beas D.O. Chaffee, M.D.</u>		22b. ADDRESS
		22c. DATE SIGNED <u>10/29/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 22, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u>
		23d. LOCATION (City, town, or county) (State) <u>Bell City Rt 1, Missouri</u>
24. FUNERAL DIRECTOR <u>Coy Shetley</u> ADDRESS <u>Bell City, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10/25/62</u>
		26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 1 1962

**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 J. J. Schuman  
Licensed Embalmer No. 4086  
P. O. Address Malden

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.