MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Andrain

Township: ~~Prairie~~ or Village: or City: Laddonia Mo (No. ____ St. ____ Ward ____)

Registration District No. 24 File No. 64

Primary Registration District No. 4018 Registered No. ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John William Stewart

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): child

DATE OF BIRTH: Jan (Month) 14 (Day), 1918 (Year)

AGE: one yrs. ____ mos. ~~one~~ ds. If LESS than 1 day: ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): none

BIRTHPLACE (City or town, State or foreign country): Laddonia Mo

PARENTS
NAME OF FATHER: Wade G Stewart
BIRTHPLACE OF FATHER (City or town, State or foreign country): Cunningham Mo
MAIDEN NAME OF MOTHER: Grace M. Morris
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Laddonia Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wade G. Stewart
(ADDRESS) Laddonia Mo

Filed Jan 16 1918 W. K. McCall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 15 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 14, 1918, to Jan 15, 1918, that I last saw him alive on Jan 15, 1918, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Shock
100 B | 51

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Contracted Pneu

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G W Monroe M. D.
Jan 16 1918 (Address) Laddonia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. 1 ds. In the State ____ yrs. ____ mos. 1 ds.
Where was disease contracted if not at place of death?
Former or usual residence none

PLACE OF BURIAL OR REMOVAL: Laddonia Mo
DATE OF BURIAL: Jan 16 1918
UNDERTAKER: W. H. McCoy
ADDRESS: Laddonia Mo

Y. WITH UNFADING INK—THIS IS A PERM
should be carefully supplied. AGE should be stated EXACTLY. PHYSI
plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im
CAUSE OF DE

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

...WITH UNFADING INK—THIS IS A PERMA...

...information should be carefully supplied. AGE should be stated EXACT... ...OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.