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

Do not use this space.

25741

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 3674 Lindell Bl ..... St. ..... Ward)

File No. ..... Registered No. 7339

2. FULL NAME Alice Stewart

(a) Residence. No. 3674 Lindell Bl St., 19 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 1858

7. AGE: Years 68 | Months 11 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Chas Sutter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

14. INFORMANT Frank Stewart
(Address) 3674 Lindell Bl

15. FILED AUG 15 1927 19.. May C Starkeos REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 ....., 1927, to to Aug 12 ....., 1927, that I last saw her alive on Aug 12 th ....., 1927, and that death occurred, on the date stated above, at 3:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
1 yr
1 yr 2 mo
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) uremic poisoning
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C A Cannon, M. D
8-13-1927 (Address) 1316 N Grand

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New St Marcus | DATE OF BURIAL Aug 15 1927

20. UNDERTAKER Wacker-Heldorle | ADDRESS 2331 S Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD