

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

Do not use this space.

18379
2121

1. PLACE OF DEATH

County Gasconade
Township Ramona City
City K.C. Missouri (No. Mersey)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME Robert S. Stewart

(a) Residence. No. 6403 E. 35th St. 14 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 5-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Minor
(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) K.C. Mo.

PARENTS
10. NAME OF FATHER Edmund Stewart
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Levasseur
12. MAIDEN NAME OF MOTHER Irma Wriston
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Edward Stewart
(Address) 6403-E-35th

15. FILED 5/27 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1929

17. I HEREBY CERTIFY, That I attended deceased from May 17 1929 to May 27 1929, that I last saw him alive on May 27 1929, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

18
Epidemic Meningitis (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Spinal Meningitis (duration) yrs. mos. ds. 10

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Fluids
(Signed) M. Brewer, M. D.
5/27 1929 (Address) K. C. Mo.

*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 North Hill DATE OF BURIAL 5-28 1929

20. UNDERTAKER Mrs. C. A. Foster City, Mo. ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

