MAR 28 1930

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

Do not use this space.

5556

File No.
Registered No. 4

1. PLACE OF DEATH
County Lawrence
Township Ozark
City (No. , St. Ward)

Registration District No. 474
Primary Registration District No. 3638

2. FULL NAME Millicae Rachel Steward

(a) Residence. No. St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W.	Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF John M Steward

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-17-1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	4	5	

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

9. BIRTHPLACE (CITY OR TOWN) Bucs Dare
(STATE OR COUNTRY) Greene Co. Mo

PARENTS
10. NAME OF FATHER James Baxter Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Susan Horn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.

14. INFORMANT Jno. M. Stewart
(Address) Halltown, Mo.

15. FILED 2-25-1930 Mrs Eliza Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Feb 22, 1930, that I last saw her alive on Feb 21, 1930, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ac Lobar Pneumonia
186A
19HR
Jaf (duration) yrs. mos. 10 ds.
CONTRIBUTORY (SECONDARY) Fracture R Hip. x-bed sores (duration) yrs. 1½ mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) Dr C. M. Barr, M. D.
2-22, 1930. (Address) Halltown, 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	DATE OF BURIAL
Halltown.	2-23 1930
20. UNDERTAKER	**ADDRESS**
J. W. Morris & Lisman	Miller Mo.

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lawrence — Registration District No. 474 — File No. .....

Township Ozark — Primary Registration District No. 5638 — Registered No. 4

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Millisae Rachel Steward

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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

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

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 7/10, 1930. Mrs Eliza Miller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fracture rt. hip and bed sores Fall
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

185
10

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-5556