

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

Do not use this space.

32798

1. PLACE OF DEATH

County Jackson Registration District No. 393
 Township Kew Primary Registration District No. 1002
 City St. Louis City Mo. (No. 53rd + Highland) St. _____ Ward _____

2. FULL NAME

James Stewart
 (a) Residence. No. 53rd Highland St. 15 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1930 yrs. Octo. mos. 1st 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 W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 77 _____ _____ _____
 or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER William Stewart

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

12. MAIDEN NAME OF MOTHER Margaret Keegan

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

14. INFORMANT Little Sisters of the Poor
 (Address) 53rd + Highland av.

15. FILED 10/3 1930 M. M. Crowe
 REGISTRAR Ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1930, to Oct 1 1930 that I last saw him alive on Oct 1 1930, and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
100
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTOR (SECONDARY) 1010
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS? Clysis
 (Signed) John Williams M. D.
 (Address) 336 Lathrop

*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 St. Mary's Cemetery DATE OF BURIAL 10/30/19

20. UNDERTAKER Duirk & Robin - 204 Linnwood
 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.

