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.

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

Do not use this space.

3508

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 739

City St. Louis Mo. (No. 4017 N. Euclid Av. St. ..... Ward)

2. FULL NAME Susan T. Stewart

(a) Residence. No. 4017 N. Euclid Av. St., 7 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: 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) Feb 12 - 1849

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
81	11	5	

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

9. BIRTHPLACE (CITY OR TOWN) St Charles
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER William Abigton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Susan Kirkpatrick
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. W. P. Kelley
(Address) 4017 N. Euclid Av.

15. FILED JAN 19 1931 19 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 17 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9th, 1927, to Jan. 17, 1931, that I last saw her alive on Jan 17th, 19....., and that death occurred, on the date stated above, at 1:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemmorhage of Brain
J2A
102
(duration) ..... yrs. ..... mos. 2 hours

CONTRIBUTORY (SECONDARY) — Chronic High Blood Pressure (duration) unknown

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) W. F. McCaskey, M.D.
(Address) 5143 Maple
K/17/31

*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: Windsor Mo.
DATE OF BURIAL: Jan 18 1931

20. UNDERTAKER: E. J. Schnur
ADDRESS: 3125 Lafayette Av.