

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

Do not use this space.

31655

1. PLACE OF DEATH

County *Stoddard*

Township *Osage*

City (No. _____) _____ St. _____ Ward _____

Registration District No. *834*

Primary Registration District No. *6097*

File No. _____

Registered No. *31*

2. FULL NAME

(a) Residence No. *1*

(Usual place of abode)

Ward _____

(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)

Married

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

Ethel Steward

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

Nov. 27, 1870

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

63

8

10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farming

(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)

Ardeola Mo

10. NAME OF FATHER

Gas. W. Steward

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14. INFORMANT (Address)

Mrs. Ethel Steward Canton, Mo R1

15. FILED

9-1-1934

Wm. Kearley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug. 7 1934

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1934 to Aug. 7 1934 that I last saw him alive on Aug. 7 1934 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Stomach

CONTRIBUTORY (SECONDARY)

46 (duration) yrs. mos. ds. H/W (duration) yrs. 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) *Wm. H. Burton M. D.*

8-7, 1934 (Address) Delta, 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

Travel Hill, Mo

Aug 8 1934

20. UNDERTAKER

John Davis

ADDRESS

Canton, 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.

JAN 27 1954