

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.

APR 24 1935

10180

1. PLACE OF DEATH

County *Beike*

Registration District No. *689*

Township *Buffalo*

Primary Registration District No. *5917*

City *Eberly*

(No. *Eberly sch dist*)

St. _____

Ward _____

2. FULL NAME *Peter Ann Stuart*

(a) Residence, No. *Eberly sch dist*

(Usual place of abode)

St. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-14-35*

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

22. I HEREBY CERTIFY, That I attended deceased from *July 1st* 19*33*, to *Mar. 14th* 19*35*.
last seen *her* alive on *Feb. 26th* 19*35*. Death is said to have occurred on the date stated above, at *11:00* m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *10-29-65*

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS *69* MONTHS *2* DAYS *15* If LESS than 1 day, _____ hrs. or _____ min.

mitral insufficiency Date of onset _____

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *None*

Other contributory causes of importance: *Chronic interstitial nephritis*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Carzville Mo*

13. NAME *M Dixon*

Name of operation *Post mortem laboratory findings* Date of _____
What test confirmed or _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Polly Ayres*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Miss Ben Harrison*
Red Jansone Mo

18. BURIAL, CREMATION, OR REMOVAL *Mo*
PLACE *Riverside Burial* DATE *3/15/35*

19. UNDERTAKER (ADDRESS) *J. H. Haeberl*
Jansone Mo

20. FILED *3/15* 19*35* *J. H. Haeberl*
Registrar.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify _____

(Signed) *J. H. Haeberl*, M. D.
(Address) *Bowling Green Mo*

