

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

16857

Do not use this space.

4391

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No.....
 (c) City..... Saint Louis..... (d) Street No. Enroute Homer G. Phillips Hosp...... St.
 (If death occurred in Hospital or Institution, write its name instead of Street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William James Stewart

(a) Residence, No. 4146 West Belle Place St. /// (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucy Shaw Stewart
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 6, 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 2 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Minister
 9. Industry or business in which work was done, as 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) Columbus Mississippi

FATHER 13. NAME Green Stewart

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable South Carolina

MOTHER 15. MAIDEN NAME Priscilla Gary

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Columbus Mississippi

17. INFORMANT (ADDRESS) Lucy Shaw Stewart 4146 West Belle Pl.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood Cem. DATE May 15, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles J. Gates 4107-09 Finney Avenue

20. FILED MAY 11 1939 J. P. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

No Physician in Attendance
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6th, 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 10:00 PM.
 The principal cause of death and related causes of importance were as follows:

Bronch Pneumonia;
Mitral Insufficiency;
Fatty Degeneration of the Heart;

Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes.

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) W. J. Perry M.D.
 (Address) 1300 Clark Avenue

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.

STATEMENT BY LICENSED EMBALMER

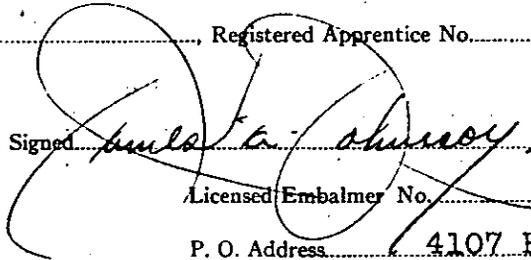
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.