

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36461

Registration District No. 3023

Primary Registration District No. 431

Registrar's No. 113

1. PLACE OF DEATH:

(a) County Johnson **REC'D NOV 7**
(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Nelda Nadine Stewart

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Apr - 10 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>6</u>	<u>0</u>	hr. _____ min. _____

9. Birthplace Warrensburg Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Nelda Wheeler
18. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Alegne Stewart
15. Birthplace Acacia Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alegne Stewart
(b) Address Warrensburg, Mo.

17. (a) Burial (b) Date thereof Oct - 11 - 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Cem

18. (a) Signature of funeral director Sweeney - Phillips
(b) Address Warrensburg, Mo.

19. (a) Oct 11, 1938 (b) Elmer Stanley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Johnson
(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")
(d) Street No. 403 West Market St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct - day 10
year 1939 hour 6 - minute 10 A. M.

21. I hereby certify that I attended the deceased from 10-5-39
_____ 1939 to 10-10-39 1939;
that I last saw her alive on 10-9 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery + Enteritis
Duration 5 days

Due to _____
Due to 11A

Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature R. Lee Cooper (M. D. certifier)
Address Warrensburg, Mo. Date signed 10/10/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 3 1939 I X1931

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/6/39

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.....

.....*Earl Priest*..... Registered Apprentice No.....
working under my personal supervision.

Signed.....*Earl Priest*.....

Licensed Embalmer No. *3878*

P. O. Address *Warrensburg, Mo.*

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.