

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

14538
Do not use this space.

Registered No. 46

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
(b) Township Carrollton Primary Registration District No. 3010
(c) City Carrollton or (d) Street No. _____ 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

363 Lina Stewart
(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife = Robert Stewart
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 16-1893
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 46 4 27
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Camden Mo.

FATHER 13. NAME David Walker

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

MOTHER 15. MAIDEN NAME Martha Johnson

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

17. INFORMANT (ADDRESS) Tom P. Stewart Carrollton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Subley Mo. DATE Apr. 14, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Standley Carrollton Mo.

20. FILED 4-13 1940 John Haskins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12 1940

22. I HEREBY CERTIFY, That I attended deceased from April 8, 1940, to April 12, 1940

I last saw her alive on April 12, 1940. Death is said to have occurred on the date stated above, at 10:30 P.M.

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

Chronic Nephritis Date of onset 1-30-40
Complicated pregnancy of 8 months gestation ✓

Other contributory causes of importance:

Name of operation None Date of _____

What test confirmed diagnosis? Ureanalysis Was there an autopsy? No

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) John H. Platz, M. D.

130 (Address) 111 S. Main, Carrollton Mo

146

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-10-40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton W

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 14538

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Lena Stewart

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced in

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 46 Months 4 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month Apr day 12 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cir. nephritis Duration _____
Complicating of preg. -
Due to: No delivery, No abortion or miscarrage

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

Major findings: _____
Of operations _____ 146
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) Manner of injury _____

23. Signature John H. Plaz (M. D. or other) _____

Address Carrollton _____

SUPPLEMENTARY

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

S-14538

Handwritten text, possibly a signature or name, located at the bottom left of the page.