No. 2
11-10-39
3-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1003

20202

State File No. 5150

Registration District No. FILED 7 9 1 7 1940 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or Institution: 5980 Wabada Ave. 2
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")

(d) Street No. 5980 Wabada Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Nettie E. Stewart 363

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chas. C. Stewart

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased October (Month) 14 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
72	7	28	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

FATHER
12. Name Robert C. Stone
13. Birthplace _____ (City, town, or county) Michigan (State or foreign country)

MOTHER
14. Maiden name Luaretia Coryell
15. Birthplace _____ (City, town, or county) Michigan (State or foreign country)

16. (a) Informant Chas. C. Stewart
(b) Address 5980 Wabada Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Jas. W. Clark
(b) Address 1125 Hodiamont Ave

19. (a) JUN 12 1940 (Date received local registrar) (b) J. P. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11 year 1940 hour 2 minute 2.10 A.M.

21. I hereby certify that I attended the deceased from June 10, 1937, to June 11, 1940, that I last saw her alive on June 11, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma Uterus	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Terminal Pneumonia	
Major findings: Infection Urinary tract etc	
Of operations: Carcinoma Uterus	
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature S. A. Weinstraub (M. D. or other)
Address 4500 Olive St. Date signed 6/9/40

(Licensed Embalmer's Statement on Reverse Side)

Dr. S. A. Weintraub
4500 Cline St.
2-5 P.M.

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 _____

Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont Ave

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

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