N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

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

26149
Do not use this space.

1. PLACE OF DEATH
(a) County St. Clair 2 Registration District No. [illegible]
(b) Township [illegible] 0 Primary Registration District No. [illegible] Registered No.
(c) City (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 Albert Roe Stewart
(a) Residence, No. St Clair Co Mo Rural
(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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-14-1873
7. AGE YEARS 66 MONTHS 6 DAYS 23 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Missouri 0

FATHER
13. NAME Ed. Stewart 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky 0

MOTHER
15. MAIDEN NAME Jane Stivers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Jess Stewart RR #1 Appleton City
18. BURIAL, CREMATION, OR REMOVAL PLACE Benton Green Cem. DATE 5-9- 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) O S Hullop Osceola Mo.
20. FILED ....., 19.... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5 7 1940
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 ....m.
The principal cause of death and related causes of importance were as follows:

Date of onset

A. Neck Broken. Killed by team of horses while working in field.

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 5-7, 1940
Where did injury occur? in field (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Runaway Team
Nature of injury Neck Broken

24. Was disease or injury in any way related to occupation of deceased? yes
If so, specify Killed by team
(Signed) O S Hullop Coroner M. D.
(Address) Osceola Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 6-40-862
Date Filed 6-11-40

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 C S Hullop

Licensed Embalmer No. 2097

P. O. Address Osceola

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.

S. No. 2B
—2-21-40
I X22659

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

State File No. 26149

Registration District No. 7685 Primary Registration District No. 6008 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Rural - Osage township
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Clair
(c) City or town rural
(If outside city or town limits write "RURAL")
(d) Street No. 2½ miles south of Johnson City Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Albert Roe Stewart
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 23 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Jess Stewart
(b) Address R.R. #1 Appleton City Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Sept 16 (Date received local registrar) (b) 40 J R Conter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature O. S. Hull Coroner
Address Osceola Mo. Date signed 5