S. No. 2
—11-10-39
v. 5-17-39
1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37968

Registration District No. 397 Primary Registration District No. 1002 Registrar's No. 4566

FILED DEC 1 1940

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether

In this community 15 Yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 2802 Park Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Zola Winn Stewart

3. (b) If veteran, name war No.

3. (c) Social Security No. 494-16-7914

4. Sex Fe.

5. Color or race Wh.

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

6. (b) Name of husband or wife Dr. S. Boyd Stewart

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

7. Birth date of deceased March (Month) 3 (Day) 1887 (Year)

8. AGE: Years 53 Months 8 Days 25 If less than one day ..... hr. ..... min.

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

10. Usual occupation Waitress

11. Industry or business

FATHER
12. Name John Boyd Winn
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rebecca
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Dr. S. Boyd Stewart

(b) Address 2802 Park Ave. City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-40 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood K.C.Mo.

19. (a) 11/30/40 (Date received local registrar) (b) B. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29 year 1940 hour 5 minute 30 A M.

21. I hereby certify that I attended the deceased from Nov. 14. 1940, 19..., to Nov. 29, 1940; that I last saw her alive on Nov 28, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Acute Haemorhagic	6 da
Due to Myocardium	
Due to Acute Gangrenous Gall Bladder	16 da
Other conditions (Include pregnancy within 3 months of death) 127	

Major findings: Of operations Gangrene of Gall Bladder (No stones)

Of autopsy same

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 1

23. Signature F B Wallace (M. D. ~~or other~~)

Address 703 Lathrop Bldg Date signed 11/29/40

(Licensed Embalmer's Statement on Reverse Side)

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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

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.