

104
 JUL 15 1941

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

22922
 Do not use this space.

1. OF DEATH
 (a) County Stanton Registration District No. 246
 (b) Township Grant Primary Registration District No. 6105 Registered No. 104
 (c) City _____ or _____ (d) Street No. 1 _____ 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. 0

2. PRINT FULL NAME Fred Ewing
 (a) Residence, No. Crown 240 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 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 _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 17 - 1897
 7. AGE YEARS 44 MONTHS 3 DAYS 21 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-9 1941
 22. I HEREBY CERTIFY, that I attended deceased from June 1 1941, to June 9 1941.
 I first saw h. alive on June 9 1941. Death is said to have occurred on the date stated above, at 19 P. m.
 The principal cause of death and related causes of importance were as follows:
Demiplegia (Cerebral complete) Date of onset 6-1-41
 Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Elka 1
 FATHER 13. NAME William A. Ewing
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio 1
 MOTHER 15. MAIDEN NAME Ellen Snow
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 1
 17. INFORMANT (ADDRESS) Stella Ewing
Crown
 18. BURIAL, CREMATION, OR REMOVAL PLACE Leo Ruth Cole DATE 6-12 1941
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Geo H Manlove
Crown Mo.
 20. FILED _____ 19 _____
 Local Registrar _____

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? _____ 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? _____
 If so, specify _____ (Signed) A P Ritten, M. D.
Crown Mo. (Address)

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.

52H

RECEIVED
District Health Officer No. 6,
District File Number 741-1200
Date Filed JUL 12 1949

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 Clay H. Malone
Licensed Embalmer No. 3827
P. O. Address Clare, 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.

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K28390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22922

Registration District No. 846

Primary Registration District No. 6105

Registrar's No.

1. PLACE OF DEATH:

(a) County Stone
(b) City or town
(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 (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3. (a) PRINT FULL NAME Fred Ewing

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

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

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 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death

Stroke (Rt. complete) 6-14-41
Due to sequela of cerebral hemorrhage 6-1-41

Other conditions (Include pregnancy within 3 months of death) g-z w

Major findings: Of operations

Of autopsy

Duration

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) (c) Means of injury

23. Signature G. P. Coyle (M. D. or other) Address Date signed

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

SUBMITTED

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4-41
-39
228390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22922

Registration District No. 846

Primary Registration District No. 6105

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Stone

(b) City or town _____
(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 Fred Ewing

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 M

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 _____ Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farm

11. Industry or business Farm & stock

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-1-41 (b) H. Q. [Signature]
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SEARCHED
SERIALIZED
INDEXED
FILED