No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32913

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 7864

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: Pronounced dead City Hosp. #2 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis Mo 5 17 (If outside city or town limits, write "RURAL")

(d) Street No. 5641 Clemens Ave 9 0 (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME ALBERT STEWARD

3. (b) If veteran, name war .....

3. (c) Social Security No. None

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife Angeline Steward

6. (c) Age of husband or wife if alive about 24 years

7. Birth date of deceased Oct (Month) 10 (Day) 1917 (Year)

8. AGE: Years 23 | Months 10 | Days 17 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business .....

FATHER 12. Name Turner Steward

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

MOTHER 14. Maiden name Malinda Armfield

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

16. (a) Informant Turner Steward

(b) Address 5641 Clemens Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-41 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director A D Richardson

(b) Address 2625 Gravois

19. (a) OCT 1 1941 (Date received local registrar) (b) [illegible] Beeduk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 28 year 41 hour 2:30 minute P. 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.

Immediate cause of death — Duration

Rheumatic Heart Disease

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 Thomas F Callaman (M. D. or other)

Address Deputy Coroner Date signed 9/29/41

(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 A. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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, fact should be so stated above.