No. 2
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I X23159

31623

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 15

109
0
0

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

1. PLACE OF DEATH:
(a) County WARREN
(b) City or town R.F.D. #2 Hickman Twp
(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: 109
(a) State MISSOURI (b) County WARREN 0
(c) City or town R.F.D. #2 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ANNIE STEWART
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FE
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife JAMES STEWART
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased OCT (Month) 13 (Day) 1871 (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	11	12	hr. min.

9. Birthplace WARREN, Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business OWN HOME
FATHER
12. Name WARREN Welch
13. Birthplace WARREN Co. (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name SUSAN EDWARDS
15. Birthplace LINCOLN Co. (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Pete Washington
(b) Address Troy Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 27 (Month) (Day) 1942 (Year)
(c) Place: burial or cremation WRIGHT CITY Mo.
18. (a) Signature of funeral director Kemper Funeral Home
(b) Address Troy Mo.
19. (a) 9/27/42 (Date received local registrar) (b) Julius Nieburg (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25 year 1942 hour 4 minute 30 A M.
21. I hereby certify that I attended the deceased from August 4, 1942 to Sept. 24, 1942 that I last saw her alive on September 24, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	
Due to Hypertension	
Due to Nephritis	
Other conditions General anasarca (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 John B. Killoran (M. D. or other)
Address Wright City, Mo. Date signed 9/25/42

242
/42

1251

(Licensed Embalmer's Statement on Reverse Side)

OCT 8-1962

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 Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address Troy, 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31623

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 15

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Warren

(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 Annie Stewart

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

3. (c) Social Security No. .....

4. Sex F

5. Color or race B

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

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

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

7. Birth date of deceased Oct (Month) 13 (Day) 18 (Year)

8. AGE: Years 70 Months 11 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo (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 .....

(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 Sept day 25

year 1942 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 Cardiac failure	
Due to Hypertension	
Due to nephritis chronic	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

131b

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (c) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....