

FILED JAN 11 1942 **12 8**

Registration District No. Primary Registration District No. **2000**

39
2
6

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

1. PLACE OF DEATH: **GREENE**

(a) County **GREENE**

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

(c) Name of hospital or institution: **903 E. GARFIELD 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **41 YR.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene 39**

(c) City or town **Springfield 2**
(If outside city or town limits, write "RURAL") **6**

(d) Street No. **903 Garfield**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **0**

3. (a) PRINT FULL NAME **HULDA E. STEWART.**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **31** at year **1942** hour **2 12** minute **40** A. M.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **Wm. B. STEWART**

6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased: **Oct 12 1901**
(Month) (Day) (Year)

I hereby certify that I attended the deceased from **12/29/42** to **12/30/42** that I last saw her alive on **12/30** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
41	2	19	hr. min.

Immediate cause of death: **Cerebral Hemorrhage**

Duration **1 da**

9. Birthplace **GREENE CO. MO. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **IN HOME**

MOTHER FATHER

12. Name **JAMES M. CAMPBELL 9**

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

14. Maiden name **FANNIE CELEY**

15. Birthplace **Unknown UNKNOWN 9**
(City, town, or county) (State or foreign country)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **ggs**

PHYSICIAN

Major findings: Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant **Jm B Stewart**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Jan 2 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pleasant Hope Cem.**

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?

18. (a) Signature of funeral director **J. W. Kingman & Co.**

(b) Address **Springfield, Mo.**

19. (a) **1-2-42** (b) **S. W. Handley**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)

23. Signature **J. A. E. Helder** (M. D. or other) **12/31/42**
Address **Springfield** Date signed **12/31/42**

MAY 26 1956

Handwritten initials

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 *J. H. Hingner*
Licensed Embalmer No. 5358
P. O. Address Springfield 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: +