

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17914

X23155
FILED JUN 7 1942 124

Registration District No. 5459

Primary Registration District No. 5459

Registrar's No. _____

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: Route 4 (About 7 Miles West on)
(If not in hospital or institution, write street number or location) "66"
(d) Length of stay: In hospital or institution 21 years
In this community 21 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39
(a) State Missouri (b) County Greene
(c) City or town Springfield,
(If outside city or town limits, write "RURAL") 0
(d) Street No. Route 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Andrew H. Stewart
(b) If veteran, name war Unknown
3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 20
year 1942 hour 5 minute 15 P.M.

4. Sex Male 5. Color or face White
6. (a) Single, widowed, married, Divorced Widowed
6. (b) Name of husband or wife Mary Elizabeth Stewart
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased March 29, 1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1 - 1942
Dec 20 - 1942 to Dec 20 1942.
that I last saw him alive on Dec - 20 1942.
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>8</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death
Cerebral - Temporal region
head - right side 2 yrs

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

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 53

10. Usual occupation Farmer
11. Industry or business On farm

Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER {
12. Name Joseph Stewart
13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Mary J. Koblegate
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. R. L. Downey
(b) Address Springfield, Missouri
17. (a) Removal (b) Date thereof 12/23/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Indianola, Iowa

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 Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 5/1/42 (b) Jewell Williams
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury 0
23. Signature E. M. LeCompte md. (M. D. or other) 0
Address Bancroft Ave md Date signed 12/21/42

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

1295-

RECEIVED

Greene County Health Office,

County File Number 43-6-62

Date Filed 6/3/43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.