

Registration District No. _____ Primary Registration District No. **4555**

1. PLACE OF DEATH:
 (a) County **Davies**
 (b) City or town **Coffey**
 (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 **54 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State: **Mo**
 (b) County **Davies**
 (c) City or town **Coffey**
 (d) Street No. _____
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Robert Russell Stewart**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **21**
 year **1944** hour **7:55** minute **00** P.M.

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Nellie Stewart** 6. (c) Age of husband or wife if alive **65** years
 7. Birth date of deceased **May 31 1877**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 19, 1944** to **Feb. 21, 1944**
 that I last saw him alive on **Feb. 21, 1944** and that death occurred on the date and hour stated above.

8. AGE: Years **66** Months **8** Days **21** If less than one day
 hr. _____ min. _____

Immediate cause of death **Virus Pneumonia**
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
Chronic Myocarditis.

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

10. Usual occupation _____

11. Industry or business **Farming**

12. Name **Charles Stewart**

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

14. Maiden name **Rachel Stephenson**

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

16. (a) Informant **Mr. Nellie Stewart**
 (b) Address **Coffey Mo**

17. (a) **Burial** (b) Date thereof **Feb 24-1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Coffey Mo**
 18. (a) Signature of funeral director **W. Brown**
 (b) Address **Patterson Mo**
 19. (a) **2-28-1944** (b) **A. J. Johnson**
 (Date received local registrar) (Registrar's signature)

Major findings: **Chronic Myocarditis.**
 Of operations _____
 Of autopsy _____
938

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 **W. Baumgardner** (M. D. or other) **2 100**
 Address **Coffey Mo** Date signed **2/22/44**

Duration **2/19 to 2/21**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

E. Schomer

Licensed Embalmer No.....

2857

P. O. Address.....

Patonsburg 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.