

**FILED AUG 9 1944**  
 Registration District No. \_\_\_\_\_

Primary Registration District No. **4267**

1. PLACE OF DEATH: **Lafayette**  
 (a) County **Lafayette**  
 (b) City or town **Odessa**  
 (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) **1**  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community **50 Yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Lafayette**  
 (c) City or town **Odessa** **54**  
 (If outside city or town limits, write "RURAL") **4**  
 (d) Street No. \_\_\_\_\_ (If rural, give location) **3**  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country. **0**

3. (a) PRINT FULL NAME **Harrison Stewart**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **not**  
 4. Sex **M** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **1864**  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **July** day **8**  
 year **1944** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from **July 1, 1943**  
**July 1, 1943** to **July 6, 1944**  
 that I last saw him alive on **July 6, 1944**  
 and that death occurred on the date and hour stated above.

8. AGE: Years **80** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Uremia**  
 Due to **Cardio-renal-vascular disease & senility**  
 Due to \_\_\_\_\_

9. Birthplace **Lexington, Mo.**  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation **laborer**

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

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
 12. Name **Sam Stewart**  
 13. Birthplace **Missouri**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Not known**  
 " " " "  
 15. Birthplace **9**  
 (City, town, or county) (State or foreign country)

Major findings: **no operating**  
 Of operations \_\_\_\_\_  
 Of autopsy **no autopsy** **131**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant **George Stewart**  
 (b) Address **Odessa, Mo.**  
 17. (a) **Burial** (b) Date thereof **July 10, 1944**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Odessa, Mo.**

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) **no accident**  
 (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)  
 Means of injury \_\_\_\_\_

18. (a) Signature of funeral director **E. H. Kiser**  
 (b) Address **Odessa, Mo.**  
 19. (a) **Aug-3-1944** (b) **Mrs. W. F. Baker**  
 (Date received local registrar) (Registrar's signature)

23. Signature **W. M. Martin** (M. D. or other)  
 Address **Odessa, Mo.** Date signed **7/7/44**

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

RECEIVED

Interior Health Officer No. 51

File Number \_\_\_\_\_  
to File 8-8-49

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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 H. Kusan*

Licensed Embalmer No. 7541

P. O. Address.....

*Osborn Ave*

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.