

**FILED SEP 10 1944**

Registration District No. \_\_\_\_\_

Primary Registration District No. **5606**

Registrar's No. **30**

1. PLACE OF DEATH:

(a) County **Johnson**  
(b) City or town **Elm, Missouri, Rural**  
(c) Name of hospital or institution: **none**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **none**  
In this community **3 years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**  
(c) City or town **Elm**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **none**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **XXXX**

3. (a) PRINT FULL NAME **BERNARD LEROY STEWART**

3. (b) If veteran, name war **none** 3. (c) Social Security No. \_\_\_\_\_

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **married**

6. (b) Name of husband or wife **Loverna Adele Stewart** 6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **August 18, 1891**  
(Month) (Day) (Year)

8. AGE: Years **53** Months **0** Days **11** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **Retired Landscaps gardner**

11. Industry or business **same**

MOTHER FATHER { 12. Name **Henry Stewart**  
13. Birthplace **Pennsylvania**  
14. Maiden name **Eliza T. Turner**  
15. Birthplace **Pennsylvania**

16. (a) Informant **Loverna Adele Stewart**  
(b) Address **Route # Kingsville, Mo.**

17. (a) **Burial** (b) Date thereof **Sept 1, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elm Springs, Mo.**

18. (c) Signature of funeral director **Canaday and Ropp**

(b) Address **Holden, Missouri**

19. (a) **9-2-44** (b) **Kathryn S. Canaday**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **29**  
year **1944** hour **7:30** minute **A** M.

21. I hereby certify that I attended the deceased from **Jan 1**  
19 **44** to **Aug 29** 19 **44**  
that I last saw him alive on **Aug 26** 19 **44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Embolism**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions **Bullet wound in rt hip**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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? \_\_\_\_\_  
(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 **Kelly Rawlins** (M. D. or other)  
Address **Holden Mo** Date signed **9/2/44**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Em  
(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 \_\_\_\_\_  
In this community 3 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bernard L. Stewart

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 52 year

7. Birth date of deceased Aug. 18 - 1891  
(Month) (Day) (Year)

8. AGE: Years 53 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 29 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Bullet wound in R. hip  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no, accident  
(b) Date of occurrence not known  
(c) Where did injury occur? not known  
(City or town) (County) (State)  
(d) Did injury occur in or about home, or farm, in industrial place, in public place? Industrial place

While at work? yes (Specify type of place) (c) Means of injury gun

23. Signature Kelly Rawlins (M. D. or other) \_\_\_\_\_  
Address Holden Mo Date signed 9/12/44

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

SUPPLEMENTARY

DEC 1 1944

DEC 4 1944

DEC 1 1944

28115