

FILED OCT 6 1944

State File No. ....

Registration District No. 197

Primary Registration District No. 55153023

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

In this community 40 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Henry

(c) City or town Near HUNTINGTONDALE  
(If outside city or town limits, write "RURAL")

(d) Street No. Shawnee Trwp.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Goldie E Stewart

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 30  
year 1944 hour 1:30 minute PM M.

21. I hereby certify that I attended the deceased from Sept 26  
1944, to Sept 29 1944;  
that I last saw her alive on Sept 29 1944;  
and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife EIMER 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: 1-19-1890  
(Month) (Day) (Year)

Immediate cause of death: Diabetic thrombus of abdomen at operation for thrombus of appendix Duration 7 days

Due to operation for thrombus of appendix

8. AGE: Years 54 Months 8 Days 11 If less than one day hr. min.

9. Birthplace: North Kansas City Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: 0

12. Name: Wm Eudicatt 0

13. Birthplace: Platte City Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name: Eugene Ray

15. Birthplace: Huntington Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Eliner Stewart

(b) Address: Clinton Mo.

17. (a) Burial (b) Date there: 10-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Paul Cemetery

18. (a) Signature of funeral director: Fred Welker

(b) Address: Clinton Mo.

19. (a) Sept. 30, 1944 (b) Georgia Kitchener  
(Date received local registrar) (Registrar's signature)

Other conditions: 0  
(Include pregnancy within 3 months of death)

Major findings: 0  
(Of operations)

Of autopsy: 0

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

(Specify type of place) (e) Means of injury 0

23. Signature: H. S. Sulfer (M. D. or other) MD  
Address: Clinton Mo. Date signed: 9-30-44

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

RECEIVED  
District Officer No. 7,  
District No. 9-44-1122  
Date Filed 10-5-44

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 Fred W. Kucera

Licensed Embalmer No. 7478

P. O. Address Clinton, 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.

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Henry Clinton  
(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_ (Specify whether  
in this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

Heldie E. Stewart

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 \_\_\_\_\_ years

7. Birth date of deceased Jan 19 1898  
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 18 If less than one day \_\_\_\_\_ min.

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

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

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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 Feb Day 26 Year 1944 hour \_\_\_\_\_ minute 2 M.

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

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 H. S. Walker (M. D. or other M.D.)

Address Clinton Mo Date signed \_\_\_\_\_

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

SUPPLEMENTAL

NOV 1 1944

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