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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13203**

Registration District No. **15**

Primary Registration District No. **2015**

Registrar's No. **17**

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

1. PLACE OF DEATH:
(a) County **CLINTON**
(b) City or town **CAMERON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
404 W 5th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **NO**
In this community **Lifetime**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Clinton 25**
(c) City or town **Cameron**
(If outside city or town limits, write "RURAL")
(d) Street No. **404 W 5th St.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **✓**

3. (a) PRINT FULL NAME **Virginia Lee Stewart**
3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Mar** day **2**
year **1945** hour **4:10** minute **PM** M.
21. I hereby certify that I attended the deceased from **Feb 27**
1945, to **Mar 1**, 1945;

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **J. M. Stewart** 6. (c) Age of husband or wife if alive **years**
Birth date of deceased **Nov. 3 1864**
(Month) (Day) (Year)

that I last saw her alive on **Mar 1**, 1945;
and that death occurred on the date and hour stated above.

8. AGE: Years **80** Months **3** Days **29** If less than one day hr. min.

Immediate cause of death **Chronic nephritis** Duration **3 yrs?**

9. Birthplace **De Kalb Ga** (City, town, or county) **MO** (State or foreign country)

Due to **arteriosclerosis**
Due to

10. Usual occupation **Housewife**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Of operations **1918** Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Leo W. Reed**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Mary J. Woods**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jesse Stewart**
(b) Address **Cameron**

17. (a) **Burial** (b) Date thereof **Mar 4 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Packard Cem**

18. (a) Signature of funeral director **Paland Funeral Home**
(b) Address **Cameron**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

19. (a) **2-2-1945** (b) **Mrs. Kathleen Harris**
(Date received local registrar) (Registrar's signature)

(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 **Ed. Templeman**
Address **Cameron Mo** Date signed **3/2/45**

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed *Rep Mrs Crunk*

Licensed Embalmer No. *2533*

P. O. Address *Lathrop 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.