

No. 2
-8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38775

FILED NOV 28 1945

State File No. _____

Registration District No. 339 Primary Registration District No. 6149 Registrar's No. 19

1. PLACE OF DEATH:
(a) County Stoddard Co
(b) City or town Dudley
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Dudley Mo R. 1
(d) Street No. _____
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME Walter Cliff Stuart
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month Oct - day 20
year 1945 hour 4 minute 30 P.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Kara Stuart
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased Nov-11 1899

21. I hereby certify that I attended the deceased from Oct 15 1945 to Oct 20 1945
that I last saw him alive on Oct 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Parkinson's agitated Duration 16 yrs

8. AGE: Years 45 Months 11 Days 9
If less than one day _____ hr. _____ min.

9. Birthplace Bloomfield Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Franklin Stuart

12. Name Franklin Stuart

13. Birthplace unknown

14. Maiden name Anna Peitz

15. Birthplace unknown

16. (a) Informant Kara Stuart

(b) Address Dudley Mo

17. (c) Burial (b) (Date thereof 10-24-45)
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wabbe Cemetery

18. (a) Signature of funeral director Walter Stuart
(b) Address Dudley Mo

19. (a) 10-24-45 (b) J. Steinmetz
(Data received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy, within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature H. Skelley (M.D. or other) Dr.
Address Dudley Date signed 10-22-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2

District File Number 1145-325

Date Filed 11-8-48

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 Lynnan Steele

Licensed Embalmer No. 2476

P. O. Address Wester 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. 339 Primary Registration District No. 6149

1. PLACE OF DEATH: Stoddard
(a) County Stoddard
(b) City or town Rural Duck Creek Twp.
(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 Walter C. Stuart
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 _____
7. Birth date of deceased Nov 11 1894
(Month) (Day) (Year)

8. AGE: Years 45 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-24-1945 (b) J. H. Steiner
(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 _____ Day _____
Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

