

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Norfolk 999
(c) City or town Norfolk
(If outside city or town limits, write "RURAL") 1st
(d) Street No. _____
(If rural, give location) N.R
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edeah M. Stuart
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 6
year 1946 hour 10 minute 30 P M.
21. I hereby certify that I attended the deceased from
at 29:45 to May 6 19 46
that I last saw h _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alfred C. Stuart
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased January 21 1894
(Month) (Day) (Year)

Immediate cause of death Malignant Lymphoma Duration about 2 years
Due to _____
Due to 55
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
52 1 15 hr. _____ min.

9. Birthplace Mokane Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: multiple nodular growths
of operations retro peritoneal
region spleen - pneumonia type
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business _____
12. Name Napoleon B. Stuart
13. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Lena Smith
15. Birthplace Mokane Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred C. Stuart
(b) Address Raleigh, North Carolina
17. (a) Burial (b) Date thereof 3-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mokane, Missouri

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?
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Robert G. Wauer (M. D. or other) MD
Address Paul Brown Bldg Date signed Nov 7-46

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Bld.
19. (a) MAR 7 1946 J. Z. Bradeck
(Date received local registrar) (Registrar's signature)

APR 18 1945

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 *Henry M. Branne*

Licensed Embalmer No. *4200*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St Louis
(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) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Edeah M. Stuart

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

4. Sex J 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..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min. 52

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

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) (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 April Day 19 Year 1946 Hour 11 minute 46 M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Female with lymphoma 3 stages of metastasis

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) (Means of injury) Robert W. Stuart

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

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

11706