

FILED MAY 5 8 1946

Registration District No. _____

Primary Registration District No. **4114**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Chariton**
(b) City or town **Mendon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Missouri** (b) County **Chariton**
(c) City or town **Mendon** **21**
(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 _____

3. (a) PRINT FULL NAME **Charles B. 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 **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased **Sept 16th 1868**
(Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **1** If less than one day _____ hr. _____ min.

9. Birthplace **Chariton Co Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **James W Stewart**

13. Birthplace **Wayne Co Ky.**
(City, town, or county) (State or foreign country)

14. Maiden name **Frances Llewellyn**

15. Birthplace **Chariton Co Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary F Stewart**

(b) Address **Mendon Mo.**

17. (a) **Burial** (b) Date thereof **4/18/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salisbury Mo.**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Mendon, Mo.**

19. (a) **4-19-46** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr.** day **17th**
year **1946** hour **1** minute **9** M.
21. I hereby certify that I attended the deceased from **Dec 2nd 1945** to **Apr 17 1946**
and that I last saw him alive on **Apr 17 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Blod clot in Brain**
Caused from Apoplexy
Due to **Apoplexy**
Due to **Cerebral rupture**

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)
(e) Means of injury _____

23. Signature **H. B. Lucas** (M. D. or other) _____
Address **Mendon Mo.** Date signed **4/17/46**

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

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

11454

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 5-2-46

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 3970

....., Registered Apprentice No.....
working under my personal supervision.

Signed A. Lipson

Licensed Embalmer No. 3970

P. O. Address Mendon MA

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.