

**FILED JUL 20 1946**

Registration District No. \_\_\_\_\_

Primary Registration District No. **5554**

Registrar's No. **5**

**1. PLACE OF DEATH:**

(a) County **Haskell**  
 (b) City or town **Lesta**  
(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 **11 yrs.**  
years, months or days

3. (a) PRINT FULL NAME **Minnie Augusta 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 **W**

6. (b) Name of husband or wife **J. F. Stewart** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **10-23-1863**  
(Month) (Day) (Year)

8. AGE: Years **82** Months **6** Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Johnson Co. Ill.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

12. Name **Ruth Whitnel**

13. Birthplace **Gay 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **Judith Miller**

15. Birthplace **Gay 1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Grover Holm**

(b) Address **Lesta, Mo**

17. (a) **B** (b) Date thereof **4-24-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Free Union**

18. (a) Signature of funeral director **R. Wilson**

(b) Address **West Plains, Mo**

19. (a) **5-29-46** (b) **Bladys Harrison**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Haskell**  
 (c) City or town **Lesta**  
(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 **4** day **22**  
 year **1946** hour **4** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **4-15-46**  
 to **4-22-46**

that I last saw him alive on **4-21-46**

and that death occurred on the date and hour stated above.

Immediate cause of death **Pudriness**

Due to **High Blood Pressure**

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

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: **43d**

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) Month of injury

23. Signature **V. E. Roe** (M. D. or other) \_\_\_\_\_

Address **Viola, Mo** Date signed **4-30-46**

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

RECEIVED

District Health Officer No 5.

District File Number 646-370

Date Filed 6-18-46

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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 L. D. Robertson

Licensed Embalmer No. 3432

P. O. Address West Haven, Ct.

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.