

FILED JUL 14 1947

Registration District No. **7**

Primary Registration District No. **3012**

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Mos. 23 days
(Specify whether years, months or days)
In this community 4 Mos., 23 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Poinsett
(c) City or town Tyronza
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Claude Steward

3. (b) If veteran, name war VW II

3. (c) Social Security No. --

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Armer Steward

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased April 29 1915
(Month) (Day) (Year)

8. AGE: Years 32 Months 1 Days 16
If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Steel Foundry

MOTHER FATHER

12. Name --

13. Birthplace --
(City, town, or county) (State or foreign country)

14. Maiden name Pearl Armon

15. Birthplace --
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration Hospital

(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 6-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marked Tree, Arkansas

18. (a) Signature of funeral director Chas. U. Hon

(b) Address HOPE FUNERAL HOME, Excelsior Springs, Missouri

19. (a) 6/18/47 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1947 hour 8 minute 25 P.M.

21. I hereby certify that I attended the deceased from January 22, 1947 to June 15, 1947;
that I last saw him alive on June 15, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis, pulmonary, chronic, far advanced, active, 4 severe
Duration Unknown

Due to _____

Due to _____

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

Major findings: 13 B
Of operations _____

Of autopsy Same as above

PHYSICIAN

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 Edw. P. Altomare M.D. or other MD

Address Veterans Administration Hosp., Excelsior Springs, Missouri signed 6-15-47

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-9-47

AUG 28 1947

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

James A. Moles

Licensed Embalmer No.

3296

P. O. Address

Exp Springs 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.