

FILED DEC 13 1947  
Registration District No. 360

Primary Registration District No. 6225

State File No. \_\_\_\_\_  
Registrar's No. 180

1. PLACE OF DEATH:

(a) County Wagon Wash. Twp.  
(b) City or town Butler  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital #3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 24 1/2 hrs  
In this community 9 years 5 months 24 days (Specify whether years, months or days)

8. (a) PRINT FULL NAME MARY B. STEWART

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife R. C. Stewart 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased 2-1-1862  
(Month) (Day) (Year)

8. AGE: Years 85 Months 00 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House

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

12. Name Minor Baker

18. Birthplace Ill (City, town, or county) (State or foreign country)

14. Maiden name Anette Gabel

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

16. (a) Informant Hospital Record

(b) Address Nebraska Mo.

17. (a) Removal (b) Date thereof Dec 8 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Des Moines Iowa

18. (a) Signature of funeral director Allen W. Deane  
(b) Address Nebraska Mo.

19. (a) 12-5-47 (b) Wathign Hancey  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates  
(c) City or town Butler  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7 year 1947 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from 7-28 1945 to 12-7 1947  
that I last saw her alive on 12-5 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Severe deterioration

Due to Proximate Shock

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

Other conditions (Include pregnancy within 3 months of death) 100

Major findings: Of operations 100

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 11-11-47

(c) Where did injury occur? at Hosp #3 Nevada Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hospital #3  
While at work? No (Specify type of place) (e) Means of injury rupture of hip

23. Signature R. H. Hill (M. D. or other) MD  
Address Nebraska Mo Date signed 12-7-47

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

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

RECEIVED  
District Health Officer No. 7,  
District No. 11-47-1433  
Date Filed 12-11-47

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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 Allen S. Hayes

Licensed Embalmer No. 1968

P. O. Address Nevada, 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, above space should be left blank.**