

S. No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

28395
State File No. _____
Registrar's No. 2040

FILED SEP 7 1948

Registration District No. 317

Primary Registration District No. 2063

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether in this community _____ years, months or days) 2 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No. 211 High St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marcellus L. Stewart

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21
year 1948 hour 10 minute 50 p.m.

21. I hereby certify that I attended the deceased from August 16, 1948, to August 21, 1948;
that I last saw him alive on August 21, 1948;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race C

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

6. (b) Name of husband or wife Goldie Shepard

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased: 11 (Month) 28 (Day) 1899 (Year)

Immediate cause of death Hemorrhage from a cerebral vessel

Duration 5 days

8. AGE: Years 58 Months 8 Days 23
If less than one day hr. _____ min. _____

Due to Hypertensive vascular disease

Due to 430

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

10. Usual occupation Janitor

11. Industry or business Web. Groves School Board

12. Name John Stewart

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

14. Maiden name unknown

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

16. (a) Informant County Hosp. Records

(b) Address Clayton, Mo.

17. (a) Burial (b) Date thereof 8-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Jackson

18. (a) Signature of funeral director C. J. Nash

(b) Address 3247 Page

19. (a) 8-30-48 (b) Carolea Shepherd
(Date received local registrar) (Registrar's signature)

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

Major findings: _____

- Of operations: _____

Of autopsy: _____

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 A. John (M. D. counties) _____
Address 601 S Brentwood Clayton Date signed 8/26/48

701 07 20

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..... *Charles King*

Licensed Embalmer No..... *4489*

P. O. Address..... *3847 Page Blvd.*

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.