

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1949

State File No. 267

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 101 PRIMARY REG. DIST. NO. 5413 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY Douglas			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Douglas		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Squires, Rural, Walls		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Squires, Rural, Walls		3/10/49
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) a. (First) Donna b. (Middle) Marie c. (Last) Steward			4. DATE OF DEATH (Month) (Day) (Year) 1-2-49		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 9-18-48		9. AGE (In years last birthday) 3 Months 14 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Rochelle, Ill.		12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME Steward Earl Steward		13b. MOTHER'S MAIDEN NAME Elda Kilburnt		14. NAME OF HUSBAND OR WIFE	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Steward Squires, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Double Bronchial Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 491X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 0		

22. I hereby certify that I attended the deceased from 1/1, 19 49, to 1/2, 19 49, that I last saw the deceased alive on 1/1, 19 49, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE R.A. Ryan (Degree or title) M.D.	23b. ADDRESS Mountain Grove, Mo.	23c. DATE SIGNED 1/9-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-4-49	24c. NAME OF CEMETERY OR CREMATORY Murray	24d. LOCATION (City, town, or county) (State) Squires, Mo.	
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DATE REC'D BY LOCAL REG. Jan. 15-49	REGISTRAR'S SIGNATURE Vestal Bushman	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Linkingbeard Funeral Home, Ava, Mo
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(Licensed Embalmer's Statement on Reverse Side)

3465  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 1

District File Number 149-125

Date Filed 1-31-49

Families request that body not be embalmed

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Chester A Roof

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3044

P. O. Address Gainesville 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.