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FILED JUN 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15671

BIRTH NO. REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 4225 Registrar's No. 37

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

3. NAME OF DECEASED (Type or Print)	a. (First) Louisa	b. (Middle) D	c. (Last) Stewart	4. DATE OF DEATH (Month) (Day) (Year)
				May 31, 1949

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 20, 1861	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 1	IF UNDER 1 YEAR Days 11	IF UNDER 1 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sullivan County, New York	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George Fries	13b. MOTHER'S MAIDEN NAME Wilhelmina Buntz	14. NAME OF HUSBAND OR WIFE Taylor Stewart
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Jas. Bowness, Mound City,	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary insufficiency</i>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4211	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Oregon (COUNTY) Holt (STATE) Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *July 1949*, 1949, to *July 31, 1949*, 1949, that I last saw the deceased alive on *July 27, 1949*, and that death occurred at *6:30 A.M.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>C. F. Newberry M.D.</i>	23b. ADDRESS <i>Oregon Mo</i>	23c. DATE SIGNED <i>0-31-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/2/49	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) Mound City, Mo.
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DATE REC'D BY LOCAL REG. 6-3-49	REGISTRAR'S SIGNATURE <i>J. C. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>...</i>	ADDRESS. Mound City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

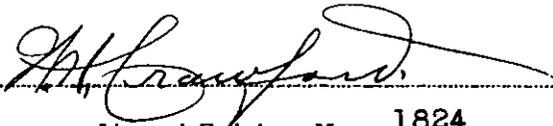
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 1824

P. O. Address Mound City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.