N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Pettis

Township: _____ or Village: _____ or City: Sedalia (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 668 — File No. 5659

Primary Registration District No. 3032 — Registered No. 38

FULL NAME Joe H. Stewart

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	widowed

DATE OF BIRTH: — (Month) — (Day), 1868 (Year)

AGE: 46 yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Flagman
(b) General nature of industry, business, or establishment in which employed (or employer): Labor

BIRTHPLACE (City or town, State or foreign country): Dont know

PARENTS
- NAME OF FATHER: Dont know
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont know
- MAIDEN NAME OF MOTHER: Dont know
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo E McCue

(ADDRESS) Sedalia Mo

Filed Feb 13, 1914. H. B. Ford, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. 12 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 21, 1914, to Feb. 12, 1914, that I last saw him alive on Feb. 11, 1914; and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) ___ yrs. ___ mos. 6 ds.

Contributory (SECONDARY) Hemiplegia

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Geo E McCue M. D.

2-13, 1914 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. 22 ds. In the State ___ yrs. ___ mos. 22 ds.

Where was disease contracted if not at place of death? Denison Tex

Former or usual residence: Denison Tex

PLACE OF BURIAL OR REMOVAL: Denison Tex

DATE OF BURIAL: Shipped 191

UNDERTAKER: McLaughlin Bros

ADDRESS: Sedalia Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory
(SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.