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.

PLACE OF DEATH

County DeKalb

Township Polk

or Village Union Star

or City

(No. St.; Ward)

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

Registration District No. 4161 File No. 5634

Primary Registration District No. 7262 Registered No. 5433

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

FULL NAME Samuel J. Stewart

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	W.	Married.

DATE OF BIRTH: Feb (Month) 12 (Day) 1842 (Year)

AGE: 78 yrs. 0 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Rock Springs Penn

PARENTS

NAME OF FATHER: John L. Stewart

BIRTHPLACE OF FATHER (City or town, State or foreign country): Rock Springs Penn

MAIDEN NAME OF MOTHER: Elizabeth A. Elder

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Rock Spring Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. R. Kirtley

(ADDRESS) Union Star Mo

Filed Feb-28 1920 E M Reynolds REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: February (Month) 21st (Day) 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan, 1919, to Feb 21st, 1920, that I last saw him alive on Feb 20th, 1920, and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

85

Arteria Sclerosis 7 yrs

Epilepsy

2 yrs (Duration) 3 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

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

(Signed) A. O. Turner M. D.

Feb 24, 1920 (Address) Union Star 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. ___ 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
Union Star	Feb 23 1920
UNDERTAKER	**ADDRESS**
W. L. & E. Cole	King City

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

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

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

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

(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**

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 import