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

Do not use this space.

26147

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Childrens Hosp (No. ..... St. ..... Ward)

File No. ..... Registered No. 7786

2. FULL NAME James Stewart

(a) Residence. No. Kirkwood MO St., R.R. 13 Box 74a. Ward. 12
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 6 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 8-15-1927

7. AGE: Years — Months — Days 6 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: X None
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kirkwood MO

PARENTS

10. NAME OF FATHER: James Stewart
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis MO
12. MAIDEN NAME OF MOTHER: Clara Haharty
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.

14. INFORMANT: M Welsh
(Address) St Louis Childrens Hosp

15. FILED SEP 1 1927, 19 Mar C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-11-1927

17. I HEREBY CERTIFY, That I attended deceased from 8-16, 1927, to 8-17, 1927 that I last saw h. 7 M. alive on 8-17, 1927, and that death occurred, on the date stated above, at 8 00 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intracranial Hemorrhage (Birth Injury)
160B 161B (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Prep. Ex. + Autopsy

(Signed) J J Donahue M.D
, 19 (Address) 500 S. Kingshighway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: POTTERS FIELD.
DATE OF BURIAL: 9-2 1927

20. UNDERTAKER: E Shannon
ADDRESS: 1921 Card

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.