

24 1929

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

Do not use this space.

31423

1. PLACE OF DEATH

County Montgomery  
Township Beek Creek  
City Keokuk (No. ....)

Registration District No. 596  
Primary Registration District No. 5787A

File No. ....  
Registered No. ....  
St. .... Ward)

2. FULL NAME

Sarah Elizabeth Stewart

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF  Jas. M. Stewart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 75 10 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Montgomery Co. Mo

10. NAME OF FATHER John J. Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Sarah Finley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Jas Adams (Address) Beek Creek Mo

15. FILED 9/20 1929 A. J. Turso REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1929 to Sept 17 1929 that I last saw her alive on Sept 19 1929, and that death occurred, on the date stated above, at 8:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Heart Insufficiency

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?  DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clemis

(Signed) H. R. Winnick, M. D. , 19 (Address) Beek Creek Mo.

\*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 Beek Creek Cemetery DATE OF BURIAL 9/22 1929

20. UNDERTAKER R. W. Poirer ADDRESS Beek Creek Mo.



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Montgomery  
Township Bellevue  
City Bellevue (No.     )

Registration District No. 596  
Primary Registration District No. 5787 B

File No.       
Registered No.      St.      Ward     

**2. FULL NAME**

Sarah Elizabeth Stewart

(a) Residence. No.      St.      Ward.       
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 02-10-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
75 10 29

**8. OCCUPATION OF DECEASED**

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

**PARENTS**  
10. NAME OF FATHER       
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)       
12. MAIDEN NAME OF MOTHER       
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)     

14. INFORMANT (Address)     

15. FILED 9/20/24 APR REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1929

17. I HEREBY CERTIFY That I attended deceased from      19     to      19     that I last saw h.      alive on      19    , 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.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH     

DID AN OPERATION PRECEDE DEATH?      DATE OF     

WAS THERE AN AUTOPSY?     

WHAT TEST CONFIRMED DIAGNOSIS?     

(Signed)     , M. D.

    , 19      (Address)

\*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      DATE OF BURIAL      19     

20. UNDERTAKER      ADDRESS     

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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