

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.

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

791  
1003

203

Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. **203**  
 (c) City ..... (d) Street No. **327 No. Ewing** St. ....  
 (e) Length of residence in city or town where death occurred ..... (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **327 No. Ewing** St. **18** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **col** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED (HUSBAND OF OR) WIFE OF **widow Walter Hall**

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**about 62**

OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **Housekeeper**  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ark**

FATHER 13. NAME **James Stewart**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ark**

MOTHER 15. MAIDEN NAME **Rosie Williams**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ark**

17. INFORMANT (ADDRESS) **James Stewart 327 No. Ewing and**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **1-6-1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Walter and Son 2769 Chaslemore**

20. FILE **JAN 6 1939** **J. P. Prudick** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12-31-1938**

22. I HEREBY CERTIFY, That I attended deceased from **8-4** 19**38**, to **12-31-38**, 19**38**. I last saw h. a. r. alive on **12-31-38**, 19**38**. Death is said to have occurred on the date stated above, at **10** a. m.

The principal cause of death and related causes of importance were as follows:

**Chronic Nephritis** Date of onset **8-1-38**

Other contributory causes of importance: **None**

Name of operation ..... Date of ..... What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19..... Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ..... Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify **None** (Signed) **Henry C. Stumpfer** M. D. (Address) **2340 Locust**

**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 .....

Registered Apprentice No. ...., working under my personal supervision.

Signed *S J Watson*

Licensed Embalmer No. *269A*

P. O. Address *2769 Chouteau*

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

**If this body is not embalmed, above space should be left blank.**