

REGD OCT 14 1939 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **1003**  
(a) County 2  
(b) City or town ST LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community at home 4007 Cook (Specify whether years, months or days) 363

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County 2  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4007 Cook and  
(If rural, give location) (11)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

3. (a) PRINT FULL NAME CLARENCE K. STEWART  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 18  
year 1939 hour 2:55 minute P M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race NEGRO  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife MARIE 6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased 9 - 26 - 1893  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 56 Months 11 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace COLUMBUS GEORGIA  
(City, town, or county) (State or foreign country)  
10. Usual occupation PULLMAN PORTER

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name WILLIAM STEWART  
13. Birthplace GEORGIA  
14. Maiden name LEON MASON  
15. Birthplace GEORGIA  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature Maie Stewart  
(b) Address 4007 Cook and  
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 22 1939  
(Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director H. W. Bruce  
(b) Address 1003 1/2 Harrison Ave  
19. (a) SEP 21 1939 (Date received local registrar) (b) \_\_\_\_\_

23. Signature Joseph M. Jones (M.D. or other) \_\_\_\_\_  
Address Deputy Prince Date signed \_\_\_\_\_

WHILE I REMAIN USE OVERDING BLACK INK—MAKE 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.

**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

*William C. McDowell*

Registered Apprentice No.

working under my personal supervision.

Signed

*William C. McDowell*

Licensed Embalmer No.

*2119*

P. O. Address

*3506 Franklind*

**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.**