

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

42658
Do not use this space.

1. PLACE OF DEATH *Quincy*
 (a) County *Quincy* Registration District No. *912*
 (b) Township *Quincy* Primary Registration District No. *6232A* Registered No. *37*
 (c) City *Quincy* (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.
20-0
 2. PRINT FULL NAME *JOHN CLAY ESTEW*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Anna Estew*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 29 1876*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 3 12
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Refractory*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Refractory*
 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) *Wright Co Mo*
 FATHER 13. NAME *Amos Estew*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Wright Co Mo*
 MOTHER 15. MAIDEN NAME *Bertha Thomas*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) *Mrs. John Estew*
Paulina Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Chapin Ill* DATE *Dec 12 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. S. Waters Paulina*
 20. FILED *Dec 12 1939* *Carrie Z. W. Back* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/10 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *3/6 1939* to *12/10 1939*
 I last saw him alive on *12/10 1939*. Death is said to have occurred on the date stated above, at *7:10 p.m.*
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
 Date of onset *3/6/39*
 Other contributory causes of importance:
Thrombosis of Lung
Asterosclerosis
 Date *12/7/39*
 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? *No*
 If so, specify _____
 (Signed) *J. P. Dougherty* M. D.
 (Address) *Paulina Mo*

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.

RECEIVED

District Health Officer No. 10

District File Number 1-40-73

Date Filed JAN 8 1940

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 Wm B. Wales

Licensed Embalmer No. 3321-

P. O. Address.....

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.