

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

5794
Do not use this space.

1. PLACE OF DEATH
 (a) County Audrain Registration District No. 27
 (b) Township Hayden Primary Registration District No. 5035
 (c) City _____ (d) Street No. _____
 (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. How long in U. S., if of foreign birth? yrs. mos. ds.
263

2. PRINT FULL NAME Jefferson Beauri Stuart
 (a) Residence, No. Audrain Co. Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (or) WIFE OF Maggie N. Stuart
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 28-1864
 7. AGE YEARS 75 MONTHS 8 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farm
 10. Date deceased last worked at this occupation (month and year) 1939 11. Total time (years) spent in this occupation Life
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calloway Co. Mo.
FATHER
 13. NAME James Stuart
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calloway Co. Mo.
MOTHER
 15. MAIDEN NAME Laura Kemp
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calloway Co. Mo.
 17. INFORMANT (NAME) (ADDRESS) J. C. Stuart
Laddonia Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Laddonia Mo. March 5, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. H. Trainger
Laddonia Mo.
 20. FILED Mar 5, 1940 Clarence James Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 3, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1940 to March 3, 1940
 I last saw him alive on March 1, 1940. Death is said to have occurred on the date stated above, at 2 P. m.
 The principal cause of death and related causes of importance were as follows:
Apoplexy
 Date of onset 2-27-40
 Other contributory causes of importance:
Arterio-Sclerosis
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No.
 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) W. K. McCall _____, M. D.
 (Address) Laddonia Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

50M-1-12-35 I X14028

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,

H. G. Grainger

....., or by

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

Signed.....
H. G. Grainger

Licensed Embalmer No. *1297*

P. O. Address *Ladonia, Mo.*

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.