

Registration District No. 784

Primary Registration District No. 111

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution Six days
In this community twenty five years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 0
(d) Street No. 6007 Pershing Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Abby H. Stewart 3152

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife C. Howard Stewart 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased November 11 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 4 If less than one day hr. min.

9. Birthplace Chicago Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife
11. Industry or business at home

MOTHER FATHER { 12. Name James Hayward

13. Birthplace Dont Know
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Dont Know

15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. Howard Stewart
(b) Address 6007 Pershing Avenue

17. (a) Cremation (b) Date thereof Feb. 17, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Thomas J. Finan
(b) Address 1519 So. Grand Blvd.

19. (a) FEB 15 1940 (b) T. R. Maguire
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15
year 1940 hour 9:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from February 7, 1940 to February 15, 1940
that I last saw her alive on February 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 8 days

Due to Staphylococci Invasions of Both Lungs

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy Multiple small Staphylococci abscesses in lungs

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? No

While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature James H. Cummings (M. D. certifier)
Address 1444 N. Euclid Ave. Date signed 2/15/40

WRITE PLAINLY—USE UNFADING 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.

WILED WAR 7-1940

940

1 X 3511

11412

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 *Thomas J. F. ...*
Licensed Embalmer No. *1197*
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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8164
Registrar's No. 317

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH: St. Louis, Mo.
(a) County St. Louis
(b) City or town St. Louis
(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 _____ (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Abby H. Stewart
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Feb. day 15 - 40
year _____ hour _____ minute _____ M.

4. Sex F 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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.

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death neuronia

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Due to stroke
Due to stroke
Other conditions both lungs
(Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: stroke
Of operations _____

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Of autopsy stroke abscess lungs

14. Maiden name _____
15. Birthplace _____ (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? _____

16. (a) Informant _____
(b) Address _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(c) Place: burial or cremation _____

23. Signature J. H. Cummings (M. D. or other) _____
Address _____ Date signed _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

