

FILED NOV 12 1940 99

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
309 Garfield Avenue 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ---
(Specify whether
In this community 12 Years
years, months or days)

3. (a) PRINT FULL NAME Mr. Carl A Stewart, Sr.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Henrietta Stewart 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased January 16 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>13</u>	<u>---</u> hr. <u>---</u> min.

9. Birthplace Scottsville New York
(City, town, or county) (State or foreign country)

10. Usual occupation Farm Machinery Salesman

11. Industry or business Retired

12. Name John E. Stewart

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Estus

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Arthur C. Johnson

(b) Address 819 E. 48th St. Dept. # 3

17. (a) Removal (b) Date thereof Oct. 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Port Huron, Michigan

18. (a) Signature of funeral director N. H. Newcomer Sr.

(b) Address 1401 Brush Creek Blvd.

19. (a) Oct. 30, 1940 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Apt. # 3, 819 East 48th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29th
year 1940 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from Oct 25
4:30 to Oct 29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Central Nervous System Sclerosis

Due to hypertension

Due to _____

Other conditions 82w
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(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? no (Specify type of place) (e) Means of injury no

23. Signature Thomas C. Carbaugh (M. D. or other) 10/30/40
Address 714 Bryant Blvd. R.C. Hill Date signed

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

MOTHER FATHER

W. H. Allen & Co.
Present Bldg - 1
~~1234 Howard St~~
9-30-18

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address F. C. No.

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.