

5-17-39
I X21492

48
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED FEB 17 1941

Registration District No. 396

Primary Registration District No. 5552

Registrar's No.

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Levasy

(c) Name of hospital or institution: *Trinitarian*

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community: _____

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Sibley

(If outside city or town limit, 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: Mary Ann Stewart

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: F

5. Color or race: White

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: William C. Stewart

6. (c) Age of husband or wife if alive: 83 years

7. Birth date of deceased: March 7 1868

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	10	3	hr. min.

9. Birthplace: Jackson County Missouri

(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business _____

12. Name: Jonathan Bridges

18. Birthplace: Jackson County Missouri

(City, town, or county) (State or foreign country)

14. Maiden name: Samara Lewis

15. Birthplace: Jackson County Missouri

(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Frank Robbins

(b) Address: Sibley

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof: Jan. 13, 1941

(Month) (Day) (Year)

(c) Place: burial or cremation: Sibley

18. (a) Signature of funeral director: *V. M. Hays*

(b) Address: *Bushong, Mo*

19. (a) Jan 15 1941 (Date received local registrar)

(b) John W. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jan day: 10

year: 1941 hour: 4 minute: 30 P.M.

21. I hereby certify that I attended the deceased from _____, 1940 to Jan 10, 1941;

that I last saw her alive on Jan 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive pneumo

Duration _____

Due to _____

Due to myocardial degeneration

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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? _____

358

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature: *L. M. Higgins* (M. D. or other) *Dr.*

Address: *Bushong, Mo* Date signed: *1/17/40*

93A

2-5-
23X 1a

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

V. M. Reppert

Licensed Embalmer No. _____

2321

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. 2880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 396

Primary Registration District No. 5552

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Osage T.P.
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Mary Ann Stewart

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 82 Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

20. DATE OF DEATH Month Jan day 10 year 1951 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Due to fever

Due to Myo Cardial degener-
ation

Other conditions _____ (Include pregnancy within 3 months of death) 108

Major findings: _____ Of operations _____

Of autopsy _____

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 _____

23. Signature L. W. Higgins (M.D. or other) MD
Address Buckner, MO Date signed 4/10/51

SUPPLEMENTAL

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

