

No. 2  
13-40  
1-239  
K23152

**FEB 25 1941** 78  
Registration District No. **8**

Primary Registration District No. **5904**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: **Phelps**

(a) County \_\_\_\_\_

(b) City or town **St James, Mo**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Soldiers Home**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 year**  
(Specify whether years, months or days)

In this community **15 months**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **81**

(c) City or town **St Louis, Mo**  
(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.? **0** years.

3. (a) PRINT FULL NAME **AWRELIAD STEWART**

3. (b) If veteran, name war **V** 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **d** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James R Stewart** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Feb 26 1865**  
(Month) (Day) (Year)

8. AGE: Years **75** Months **11** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St Louis, Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business \_\_\_\_\_

12. Name **don't know**

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 **Gus Bulick**  
(b) Address **St James, Mo**

17. (a) **Burial** (b) Date thereof **Feb 5-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Louis, Mo**

18. (a) Signature of funeral director **E. E. Nichols**  
(b) Address **St James, Mo**

19. (a) **2/27/41** (b) **Elaine B. Hawk**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **3**  
year **1941** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **January 3, 1941**, to **February 3, 1941**; that I last saw him alive on **February 27, 1941**; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic hepatitis ascites**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: **12/13**  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **C. W. Hammer** (M. D. or other) **D**  
Address **St James** Date signed **2.3.41**

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

133

RECEIVED

District Health Officer No. 5,

District File Number 24/231

Date Filed \_\_\_\_\_

**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 \_\_\_\_\_

*me*

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *Orval E. LeBlond*

Licensed Embalmer No. 3546

P. O. Address *St. James*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3857

Registration District No. 678

Primary Registration District No. 5904

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town James 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

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Aureliad Stewart

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Feb day 3  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race w

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

7. Birth date of deceased (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 75 Months 11 Days 7 If less than one day \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

PHYSICIAN

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) 6-9-41 (b) Elaine B. Houk  
(Date received local registrar) (Registrar's signature)

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 C. J. Hammel (M.D. or other) \_\_\_\_\_  
Address St James Date signed \_\_\_\_\_

SUPPLEMENTARY

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

Underline the cause to which death should be charged statistically.

