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4-41
7-39
DX26390

Registration District No. 399

Primary Registration District No. 1002

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 7 1/2 East 8th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 30 years (Specify whether)
years, months or days

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. 7 1/2 East 8th St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James A. Stewart

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

4. Sex male race white 5. Color or 0
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Selina 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Dec 25 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>6</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Bartender

11. Industry or business Saloon

MOTHER FATHER { 12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Fred G. Cloud
(b) Address 7 1/2 East 8th St

17. (a) Removal (b) Date thereof July 15 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles, Ill

18. (a) Signature of funeral director Joy Funeral Home

(b) Address 3146 Main St. K. C. Mo

19. (a) July 15 1941 (b) W. M. Crowe
(Date registered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1941 hour 10 minute 35 A. M.

21. I hereby certify that I attended the deceased from June 21 40
July 14 1941 to July 12 1941
that I last saw him alive on July 12 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke Duration _____

Due to Chronic arteriosclerosis
Due to stroke

Other conditions (Include pregnancy within 8 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
131a
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) _____
While at work? (c) Means of injury _____

23. Signature E. W. Stovell (M. D. or other) MD
Address 3103 Locust Date signed 7-14-41

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

JUL 25 1941

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 *Park G. Rowe*

Licensed Embalmer No. *2347*

P. O. Address *T. C. 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, fact should be so stated above.

(b) .01
and

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

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41
39
26390

FILED AUG 16 1941

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 2663

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: 112 E 8th St
(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 James A. Stewart

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

4. Sex M. 5. Color or race _____ 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 73 Months _____ Days _____ 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 11274 _____ (c) M. H. Brown _____ (Registrar's signature)

(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1941 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 _____
Do you have the original on this case? We do not have it, nor do we have a necropsy report stating that it was forwarded to the State Office.

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

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply
the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.