

Registration District No. 170

Primary Registration District No. 5628

Registrar's No.

1. PLACE OF DEATH:  
 (a) County Laclede  
 (b) City or town Laclede Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Falcon Mo  
 (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 Nancy Bell Steward  
 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 single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Feb 9 1917  
 (Month) (Day) (Year)

8. AGE: Years 25 Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Anton Mo  
 (City, town, or county) (State or foreign country)

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

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

MOTHER FATHER  
 12. Name S. F. Steward  
 13. Birthplace Pulaski Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Elsie Logan  
 15. Birthplace Pulaski Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant S. F. Steward  
 (b) Address Falcon Mo

17. (a) Burial (b) Date thereof 8 17 42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Home

18. (e) Signature of funeral director: PALMER'S  
 (b) Address LEBANON MO

19. (a) Aug 31-42 (b) Grace Roper  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County LACLEDE 53  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 0  
 (d) Street No. FALCON (If rural, give location) 0  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
 year 1942 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from 8-10-42  
5 1942 to 8-14- 1942  
 that I last saw her alive on 8-14- 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Analysis of cardiac centers in the nucleus  
 Due to: Pressing of cephalic tumor at base of brain  
 Due to: in floor of 4th ventricle central location  
 Other conditions: Underdeveloped Situation  
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

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

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

23. Signature Roland E. Gaston (and other) D.O.  
 Address Nebo Mo Date signed 8-18-42

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

RECEIVED

*L. C. Health Dept*  
District Health Officer No. \_\_\_\_\_

Register File Number 9-42-122

Date Filed 9-3-42

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 \_\_\_\_\_

*Not Embalmed*

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

working under my personal supervision.

Signed \_\_\_\_\_

*R. W. Bahner*

Licensed Embalmer No. 1161

P. O. Address Selznor 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27535  
Registrar's No. \_\_\_\_\_

Registration District No. 170

Primary Registration District No. 5628

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Nancy Bell 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 Feb 9 1907  
(Month) (Day) (Year)

8. AGE: Years 25 Months 6 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_) min. \_\_\_\_\_

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

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

11. Industry of 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death: Paralysis of the medulla

Due to: Pressure of Cerebellar tumor at base of brain  
Due to: in floor of 4th ventricle Central location  
Other conditions: Underdeveloped Pituitary

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.

SUPPLEMENTARY

Change due to the duration of epidemic Spring to Fall - WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

