

no. 2
9-4-41
17-39
X2948

State File No.

FILED APR 7 1943 145

Registration District No.

Primary Registration District No. 2866

Registrar's No. 3

1. PLACE OF DEATH: **C3**

(a) County Iron

(b) City or town Iron

(c) Name of hospital or institution: Iron

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

In this community most of her life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent **33**

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? X (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Susan E. Stuart

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11 year 1943 hour 7 minute 5 A M.

4. Sex female 5. Color or race W

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

6. (b) Name of husband or wife John N. Stuart

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

7. Birth date of deceased: Oct 27 1863

21. I hereby certify that I attended the deceased from March 10 1943, to March 11 1943

that I last saw her alive on March 10 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 4 Days 14 If less than one day hr. min.

Immediate cause of death traumatic pneumonia

9. Birthplace Webster Mo

Due to fall

10. Usual occupation housewife

Due to

11. Industry or business

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER { 12. Name William H Davis

13. Birthplace --- Ga.

14. Maiden name Mary Hensley

15. Birthplace Georgetown Mo

Major findings: Of operations ✓

Of autopsy no

16. (a) Informant William H Stuart

(b) Address Bixby Mo

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

17. (a) burial (b) Date thereof Mar 13 1943

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

(b) Date of occurrence ✓

(c) Where did injury occur? ✓

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director W. H. Stuart

(e) While at work? no (Specify type of place)

(f) Means of injury fall

19. (a) 3-12-43 (b) for B. W. Stuart

23. Signature W. H. Stuart (M. D. or other)

Date signed 3-12-43

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

RECEIVED

District Health Officer No. 4
District File Number 443-1997
Date Filed 4-6-43

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 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. 10411
Registrar's No. 3

Registration District No. 145

Primary Registration District No. 5-565

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

1. PLACE OF DEATH:

(a) County Iron
(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 _____ years, months or days

3. (a) PRINT FULL NAME Susan E. Stuart

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 W

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

7. Birth date of deceased Oct 27 1888
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days _____ (If less than one day _____) min.

9. Birthplace Wash D.C. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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 March year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ live on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Traumatic pneumonia

Due to _____

Due to Fall Stripped her chest over Back of chair

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

Major findings: Of operations _____ 186a
Of autopsy _____ 18

Duration _____
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) Accident

(b) Date of occurrence March 6 - 43

(c) Where did injury occur? at home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place? at home on farm (Specify type of place) While at work? yes (Specify type of place) Means of injury Fall

23. Signature Op. G. DeLeon (M. D. or other) _____

Address Salem Date signed 3-13-43

SUPPLEMENTARY

