

Registration District No. 34

Primary Registration District No. 5117

Registrar's No. 34

1. PLACE OF DEATH:
 (a) County Boone
 (b) City or town Columbia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: X
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone 10
 (c) City or town Columbia Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Cedar T. S.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME Sallie Will Stuart
 3. (b) If veteran, name war X
 3. (c) Social Security No. X

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife John H. Stuart
 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased March 16, 1854
 (Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 3
 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business " "

12. Name James Davis

13. Birthplace D. K. Ky
 (City, town, or county) (State or foreign country)

14. Maiden name Marion Ellis

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

16. (a) Informant Henry Roth

(b) Address Columbia Route 4

17. (a) Burial (b) Date thereof May 21-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Salem

18. (a) Signature of funeral director R. Rowlett

(b) Address Columbia Mo

19. (a) July 6, 1943 (b) Mrs. Alice Estes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 19
 year 1943 hour 3:15 minute P. M.
 21. I hereby certify that I attended the deceased from May 10
 1943 to May 19, 1943
 that I last saw her alive on May 18, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Abscess left lung
Chronic pulmonary
tuberculosis,
 Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 13 Pl
 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) (c) Means of injury

23. Signature A. B. Fryer (M. D. or other)
 Address Ashland Mo Date signed 5-20-43

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

6
2
4

1244

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.....

Powell

Licensed Embalmer No. *3183*

P. O. Address..... *Columbia 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 101
Registrar's No. 34

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Columbia
(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 Sally W. 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased mar 16 1915
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days _____ If less than one day _____ min.

9. Birthplace mo.
(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 _____
(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 mar Day 9
year 1983 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
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.

SUPPLEMENTARY

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

20816