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FILED MAR 15 1944

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital 270 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 m 7 d (Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert Stewart

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

4. Sex Male 5. Color or race White

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 5 7
(Month) (Day) (Year)

8. AGE: Years 58 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Labourer

11. Industry or business

12. Name Donald Stewart

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

14. Maiden name Kate Rankin

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

16. (a) Informant Record

(b) Address

17. (a) Removal (b) Date thereof 2 26 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia 3rd

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia 3rd

19. (a) 2-26-44 (b) Joan M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

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

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1944 hour 3-15 minute 0 M.

21. I hereby certify that I attended the deceased from 2-18-1944, to 2-20-1944
that I last saw him alive on 2-20-1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocarditis

Due to _____

Paralysis agitans

Blood syphilis

Other conditions (include pregnancy within 3 months of death)

Major findings: 30%

Of operations _____

Of autopsy _____

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) _____

(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)

(b) Means of injury _____

23. Signature George H. Reers (M. D. or other) MS.

Address Fulton Mo. Date signed 2/25/44

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-14-44.....

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.