

S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7418
Registrar's No. 286

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town (Kearney) Koch
(c) Name of hospital or institution Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 Days
In this community 50 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gas
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3400 FRANKLIN
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JORDAN SAMUEL STEWART
(b) If veteran, name war YES: WAR I
(c) Social Security No. YES ?

4. Sex MALE 5. Color of race NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife VIRGINIA GREGG STEWART
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased 12 31 95
(Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 8
If less than one day hr. min.

9. Birthplace RIKE COUNTY MO
(City, town, or county) (State or foreign country)

10. Usual occupation N.I.

MOTHER FATHER
11. Industry or business _____
12. Name AUGUSTUS STEWART
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name SALLY REID
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Koch Hosp. Koch, Mo

17. (a) Burial (b) Date thereof Feb - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eolia mo

18. (c) Signature of funeral director N E Gooch

(b) Address Eolia mo

19. (a) 2-10-47 (b) Paul Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 8
year 47 hour 8 minute 03 A.M.
21. I hereby certify that I attended the deceased from 12 20
1946 to 2 - 8 1947
that I last saw him alive on 2 - 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis about one year
Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy Chronic Pul Tuberculosis
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)
(e) Means of injury _____

23. Signature Bernard Friedman (M. D. or other) M.O.
Address Koch Hosp. Koch Mo. Date signed 2-1-47

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

