

FILED AUG 16 1940 STANDARD CERTIFICATE OF DEATH

State File No. 28318

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 231

1. PLACE OF DEATH: **FILED SEP 19 1940**  
 (a) County Cole  
 (b) City or town Jefferson City, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 Days  
 (Specify whether  
 In this community  
 years, months or days)

8. (a) PRINT FULL NAME ELIZABETH STROPE 361  
 8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Phillip Strope 6. (c) Age of husband or wife if alive Dec. years  
 7. Birth date of deceased November 5, 1870  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 9 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business  
 MOTHER FATHER { 12. Name Anton Herigan 6  
 18. Birthplace Germany (City, town, or county) (State or foreign country)  
 14. Maiden name Anna Wankum 6  
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Anton Strope  
 (b) Address Jefferson City, Mo.

17. (a) Burial (b) Date thereof 9/2/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Thomas, Mo.

18. (a) Signature of funeral director [Signature]  
 (b) Address Jefferson City, Mo.

19. (a) 9/2/40 (b) D. B. Strope M.D.  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State 0 Missouri (b) County Cole  
 (c) City or town St. Thomas, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29th  
 year 1940 hour 8:50 P. Minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Aug 27  
1940 to Aug 29 19 40  
 that I last saw her alive on Aug 29 19 40  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Pneumonia Hypostatic  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Emphysema of gallbladder  
 (Include pregnancy within 9 months of death)  
& cholelithiasis  
 Major findings:  
 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)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature Thomas J. Kelly M.D. (M.D. or other)  
 Address Jefferson City, Mo. Date signed Sept 4

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

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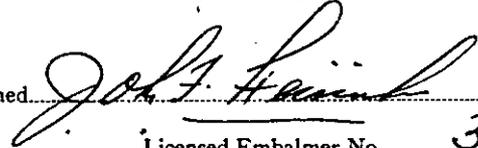
**STATEMENT BY LICENSED EMBALMER**

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.....

3655

P. O. Address.....

Jefferson City, 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28318**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County **Colfax**  
(b) City or town **Jefferson**  
(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 **Elizabeth Strope**

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 **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **69** Months **9** Days **24** If less than one day \_\_\_\_\_ min.

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

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

11. Industry or 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

20. DATE OF DEATH: Month **Aug** day **29**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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  
**Pneumonia, hypostatic**  
**bronchial pneumonia**

Other conditions **Empyema of Gall-Bladder**  
(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 \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

