

Registration District No. 838 Primary Registration District No. 4509 Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Dexter
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
 (c) City or town Dexter, Mo. Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Route #3
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Virginia Lucille Stroud 363

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased 2 9 1939
(Month) (Day) (Year)

8. AGE: Years 1 Months 6 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Oscar Stroud
 13. Birthplace Stoddard Co. Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Ruth Jordan
 15. Birthplace Bernie, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar Stroud
 (b) Address Dexter, Mo. Route #3

17. (a) Burial (b) Date thereof 8 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cycamore Cemetery

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20
 year 1940 hour 2 minute _____ P.M.

21. I hereby certify that I attended the deceased from Aug-16-1940
 _____, 19 _____, to Aug-20, 19 40
 that I last saw her alive on Aug 16, 19 40
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to _____
 Due to _____

Other conditions Whooping Cough (9)
(Include pregnancy within 3 months of death)

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?

755 While at work? A (Specify type of place) _____
 (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
 Address Dexter Mo Date signed 8/20/40

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

RECEIVED

District Health Officer No. 2,

District File Number 940-14

Date Filed 9/10/40

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.....

Body not embalmed

Registered Apprentice No.

working under my personal supervision.

Signed *Harry Johnson*

Licensed Embalmer No. 3704

P. O. Address Seaton, N

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.