

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 193

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Near Farmington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mo. 13 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington  
(c) City or town Irondale  
(If outside city or town limit, write "RURAL")  
(d) Street No. 0  
(If rural, give location) 0000  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Emily Stroup

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 Widowed

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 82 Months Un. Days Un. If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Unknown

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 Records of State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 11-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery of State Hospt.

18. (a) Signature of funeral director Neidert Funeral Home

(b) Address Farmington, Mo.

19. (a) Nov-18-40 (b) B. J. Robinson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15  
year 1940 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from 7-22, 1940, to 11-15, 1940, that I last saw her alive on 11-14, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage, massive Duration 3 days

Due to Arteriosclerosis, generalized & marked ?

Due to \_\_\_\_\_

Other conditions Simple Psychosis, Simple Dementia 1 1/2 years  
(Include pregnancy within 3 months of death)

Major findings: Of operations [Signature] Of autopsy \_\_\_\_\_

Duration  
? 3 days  
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 [Signature] (M. D. or other) IMA

Address Farmington, Mo. Date signed 11/20/40

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

DEC 17 1940

---

---

**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 the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.

*(not embalmed)*