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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JUL 30 1945

State File No. 25113

Registration District No. 367 Primary Registration District No. 6076 Registrar's No. 1828

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Marys Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26
(c) City or town St Thomas 0
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 0
(If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME Simon Strope
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosa
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Jan. (Month) 31 (Day) 1894 (Year)

8. AGE: Years 50 Months 8 Days 10 If less than one day 1 hr. min.

9. Birthplace St Thomas, Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation ~~Garage~~ Garage man
11. Industry or business
FATHER
12. Name Phillip Strope
13. Birthplace St Thomas Mo 0 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Herigon
15. Birthplace St Thomas Mo 0 (City, town, or county) (State or foreign country)
16. (a) Informant Rosa Strope
(b) Address St Thomas Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation St Thomas Cem
18. (a) Signature of funeral director Smocher Fun'l Home
(b) Address Jefferson City Mo.
19. (a) 7-21-45 (Date received local registrar) (b) E G McGavran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19th year 1945 hour 12 minute 5 P.M.

21. I hereby certify that I attended the deceased from July 12, 1945, to July 19, 1945 that I last saw him alive on July 19, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lymphogenous Leukemia with terminal broncho-pneumonia	Uncertain
Due to 74a	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Confirmed diagnosis given above

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

23. Signature G O Brown (M. D. or other) MD
Address 1325 S. Grand Date signed 7/19/45

7-9 (Licensed Embalmer's Statement on Reverse Side)

MAR 15 1946

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 Paul A. Franklin, Registered Apprentice No. ....., working under my personal supervision.

Signed Paul A. Franklin

Licensed Embalmer No. 3472

P. O. Address 4911 Washington

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.