DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
17031
IN THIS SPACE

FILED MAY 23 1946

STATE BOARD OF HEALTH
Division of Vital Statistics, State of ~~Kansas~~ Mo.

Registrar's No. 156-2001

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1. PLACE OF DEATH:
(a) County Jasper
(b) City or township Joplin
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution: General Hospital O
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 10 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Pike
(c) City or town Quincy
(If outside city or town limits, write RURAL)
(d) Street No. 710 North 4th St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3 (a) FULL NAME John Knox Stroup
3 (b) If veteran, name war ——
3 (c) Social Security No. ——
4. Sex M. 1
5. Color or race White
6 (a) Single, widowed, married, divorced Widowed
6 (b) Name of husband or wife ——
6 (c) Age of husband or wife if alive ..... years
7. Birth date of deceased May 3 1852
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
93	11	18	..... hr. ..... min.

9. Birthplace Talladaga Ala.
(City, town or county) (State or foreign country)
10. Usual occupation Lumbering
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace unk.
(City, town or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace unk.
(City, town or county) (State or foreign country)
16 (a) K. Stroup
(Informant's own signature)
(b) Address Baxter Spgs Kas.
17 (a) Removal (b) Date thereof 4-21-46
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Lewistown, Mo.
(Name and address of cemetery)
18 (a) Signature of funeral director Hoskins-Wene
(b) Address Baxter Springs
19 (a) 4-21-46 (b) Ed D Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month 4 Day 21 Year 46.
Hour 5 Minute 01 Am.
21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....
that I last saw him alive on 4-21, 1946.
and that death occurred on the date and hour stated above.

	DURATION
Immediate cause of death Arteriosclerosis	15 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 [illegible] (M. D. or other) DO
Address Baxter Spngs Kan Date signed April 21-46

N. B.—[illegible]NLY, WITH UNFADING INK—THIS IS [illegible]ENT RECORD. Every item of information [illegible] carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

20-26-[illegible] 15912 [illegible]-50M

46-4-371

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) Walter Hoskins

Licensed Embalmer No. 1896

P. O. Address Butler Spr. Cons

NOTE: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.

If this body is not embalmed, fact should be so stated above.

JAN 2 1940