

No. 2
-12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5348**
Registrar's No. **21**

Registration District No. **383** Primary Registration District No. **5655**

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

1. PLACE OF DEATH:
(a) County **Lawrence**
(b) City or town **Mt. Vernon**
(c) Name of hospital or institution: **Missouri State Sanatorium**
(d) Length of stay: In hospital or institution **4 days**
In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(d) Street No. **1104 So. 10th St.**
(e) Citizen of foreign country? (Yes or No) **No**

3. (a) PRINT FULL NAME **Martin Luther Strope**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **491-10-1648**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **9th** year **1947** hour **8:30** minute **A** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Annie Strope** 6. (c) Age of husband or wife if alive **Unknown** years
7. Birth date of deceased **Nov. 6 1881**

21. I hereby certify that I attended the deceased from **Feb 5 1947** to **Feb. 9 1947** that I last saw him alive on **Feb 9 1947** and that death occurred on the date and hour stated above.
Immediate cause of death **Bilateral Pulmonary Tuberculosis** Duration **unknown**

8. AGE: Years Months Days If less than one day
65 3 3 hr. min.

Due to
Due to

9. Birthplace **Mirabile Missouri**
10. Usual occupation **Glue maker**

Other conditions
Major findings: Of operations

MOTHER FATHER
11. Industry or business
12. Name **Wm. K. Strope**
13. Birthplace **Mirabile Missouri**
14. Maiden name **Jennie Maggie Brennaman**
15. Birthplace **Edwin Virginia**

Physician
Underline the cause to which death should be charged statistically.
Of autopsy **Bilateral pulm. Tbc. cavitation**
Arteriosclerosis **Atrophy of spleen**

16. (a) Informant **E. McMichael, Record Clerk**
(b) Address **Mo. State San. Mt. Vernon, Mo.**
17. (a) **Removal** (b) Date thereof **2-9-1947**
(c) Place: burial or cremation **St. Joseph**
18. (a) Signature of funeral director **Geo. B. Orr**
(b) Address **1111 W. 10th St. Mt. Vernon, Mo.**
19. (a) **2/9/47** (b) **D. K. Shelton**

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place)
(c) Means of injury
23. Signature **C. A. Brasher, M.D.**
Address **Mount Vernon, Mo.** Date signed **2-9-47**

RECEIVED

District Health Officer No. 6;

District File Number 247-238

Date Filed FEB 18 1947

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 George B. Orr

Licensed Embalmer No. 946

P. O. Address Mt Vernon Me

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.