

FILED SEP 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29945**
Registrar's No. **490**

BIRTH NO. _____		REG. DIST. NO. 43		PRIMARY REG. DIST. NO. 3007		State File No. 29945		Registrar's No. 490		
1. PLACE OF DEATH a. COUNTY Butler				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff				c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bloomfield				
d. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hospital				d. STREET ADDRESS (If rural, give location) 1						
3. NAME OF DECEASED (Type or Print) a. (First) Wm. b. (Middle) IVORY c. (Last) STROUP			4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1954							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 19, 1881		9. AGE (In years last birthday) 73		
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laborer of Detroit, Street Dept.		11. BIRTHPLACE (City and State or Foreign Country) Near Leora, Missouri		
						12. CITIZEN OF WHAT COUNTRY? U.S.				
13a. FATHER'S NAME Thomas B. Stroup			13b. MOTHER'S MAIDEN NAME Sarah E. Terry			14. NAME OF HUSBAND OR WIFE Mrs. Nettie Stroup				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 376-01-9209			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Nettie Stroup, Bloomfield, Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Asphyxiation Cardiac Failure Cerebral Hemorrhage Hypertensive arteriosclerosis										
19a. DATE OF OPERATION										
19b. MAJOR FINDINGS OF OPERATION										
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 331X					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR					
22. I hereby certify that I attended the deceased from 9-13, 1954 , to 9-14, 1954 , that I last saw the deceased alive on 9-14, 1954 , and that death occurred at 2:30 p.m. , from the causes and on the date stated above.										
23a. SIGNATURE C. D. Parker M.D. Poplar Bluff, Mo. (Degree or title)					23b. ADDRESS			23c. DATE SIGNED 9-17-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept. 17, 54		24c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.			24d. LOCATION (City, town, or county) (State) Stoddard Co. Missouri			
DATE REC'D BY LOCAL REG. 9/24/54		REGISTRAR'S SIGNATURE C. H. Mueller 489			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHILES UND. CO. Bloomfield, Mo.					

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED

SEP 27 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

OCT 7 1954

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, & by Lulu

Cooper #3499

SOCIETY/EMBALMER No. _____

working under my personal supervision

Student
Student Embalmer

Signed Jesse B. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, Mo.

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.