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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017005

STATE FILE NUMBER

FILED JUN 9 1959 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 200

1. PLACE OF DEATH
a. COUNTY: CAPE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CAPE GIRARDEAU — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): SOUTHEAST MO. HOSP. — Length of stay in 1b: 6 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: SCOTT
c. CITY OR TOWN: CHAFFEE — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 201 NORTH THIRD ST. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: (MN) Last: STROUD
4. DATE OF DEATH: Month: MAY Day: 28 Year: 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: SEPT. 13 1880
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months 8 Days 15 — IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RLWY. CONDUCTOR (RET.)
10b. KIND OF BUSINESS OR INDUSTRY: FRISCO RLWY. CO.
11. BIRTHPLACE (City and state or country): SELIGMAN, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: WILLIAM D. STROUD
13b. MOTHER'S MAIDEN NAME: MARY COBBIER
14. NAME OF HUSBAND OR WIFE: OLLIE PYATT STROUD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. CHARLES STROUD Address: CHAFFEE, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 177X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Transitional Cell Carcinoma of Bladder
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-7-59, to 5-28-59 and last saw her/him alive on 5-28-59
Death occurred at 1:15 Am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) 2
22b. ADDRESS: Cape Girardeau Mo
22c. DATE SIGNED: 6-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: MAY 30, 1959
23c. NAME OF CEMETERY OR CREMATORY: UNION PARK CEM.
23d. LOCATION (City, town, or county) (State): CHAFFEE, MO.

24. FUNERAL DIRECTOR ADDRESS: BISPLINGHOFF FUNERAL HOME CHAFFEE, MO.
25. DATE RECD. BY LOCAL REG.: 6-3-1959
26. REGISTRAR'S SIGNATURE: Irene Kasten

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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JUN 9 1959

JUN 18 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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