

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034155

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **8426** STATE FILE NUMBER

FILED AUG 22 1963

VS 300
Rev. 4/59

1

2 **22**

3

4 **1**

5 **2**

6

7 **0**

8 **1**

9

10

11

12 **58-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in Tb	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deconess hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1946 Sidney St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Martha Mae Stroup			4. DATE OF DEATH Month Day Year August 16 1963		5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 9/27/1879		9. AGE (last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Fred Luehm			13b. MOTHER'S MAIDEN NAME Maude Rosa			14. NAME OF HUSBAND OR WIFE Albert A. 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. 443X		17. INFORMANT Address Fred W. Stroup 3242 Missouri Av.		18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) CHRONIC PYELONEPHRITIS DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS YEARS YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 16.)						
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 8/6/63 to 8/16/63 and last saw her alive on 8/10/63 Death occurred at 3:10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.		22b. ADDRESS St Louis 19, Mo.		22c. DATE SIGNED 8/19/63 (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/20/63		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) St. Louis Co. Mo.				
24. FUNERAL DIRECTOR Gebken Sons		ADDRESS 2630 Gravois		25. DATE RECD. BY LOCAL REG. AUG 19 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> Roal Smith, M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Harold M. Simon

Licensed Embalmer No. _____

4343

P. O. Address _____

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

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