# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

35792

JAN 20 1928

1. PLACE OF DEATH
County Wayne
Township Cedar Creek
City ..... (No. ..... St. ..... Ward)

Registration District No. 893
Primary Registration District No. 6195

File No. .....
Registered No. .....

2. FULL NAME Caleb S. Stroup

(a) Residence. No. ..... St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| Male | White | widowed |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16, 1865

| 7. AGE YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 62 | 7 | 10 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Wayne Co., Mo

PARENTS

10. NAME OF FATHER Sidney A Stroup
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) North Carolina
12. MAIDEN NAME OF MOTHER Lydia Whitener
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Madison Co Mo

14. INFORMANT Jno Stroup
(Address) Gravelton, Mo

15. FILED 11/30, 1927 J. F. Gaullus
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 26 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan ....., 1923, to Nov 26, 1927 that I last saw him alive on Nov 26, 1927, and that death occurred, on the date stated above, at 3.00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sarcoma Pelvis.

5 [illegible] (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Adam F. Wagner, M.D
11-27, 1927 (Address) Gravelton, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Ev. Luth. Cemetery | 11-27- 1927 |
| 20. UNDERTAKER | ADDRESS |
| L. O. Keathley | Cascade, Mo. |

Dear State Reg:-

I am returning this Supplementary just as Dr Wagner returned it to me. Perhaps you can fill in required information from Phile and note enclosed.

J. F. Collins
(Local Reg)

S(3)-35792
1927

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Wayne — Registration District No. 893 — File No.
Township Cedar Creek — Primary Registration District No. 6193 — Registered No.
City (No. , St. Ward)

2. FULL NAME Caleb S. Stump
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTY)

PARENTS OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED , 19 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 26 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sarcoma Pelvis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY 46

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETE AS PRESCRIBED BY LAW
In plain terms, so that it may be properly classified. Exact statement of OCCUPATION

S(3)-35792