

OCT 28 1930

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

Do not use this space.
32299

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 130
Township Liberty Primary Registration District No. 5181
City _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

James, Franklin Stroder
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed Husband of Wada Stroder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 13 - 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 8 30

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) Cape Girardeau Co.

PARENTS

10. NAME OF FATHER Alexander Stroder

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Cape Girardeau Co.

12. MAIDEN NAME OF MOTHER Maud Simpson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Cape Girardeau Co

14.

INFORMANT Bob Stroder
(Address) Whitewater, Mo.

15.

FILED Oct 4 1930 J. M. Slegle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 2 1930

17. HEREBY CERTIFY, That I attended deceased from Oct 2 1930 to Oct 3 1930
that I last saw him alive on Aug 10 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Second Stroke of apoplexia
(duration) _____ yrs. 6 mos. 24 ds.
CONTRIBUTOR Arteriosclerosis, Hard
(SECONDARY) blood vessels due to old age
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Place of Birth

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE _____
WAS THERE AN AUTOPSY? Physical Examination
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. M. Finney _____ M. D.
.19 (Address) Wagler, 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 Stroder Cemetery DATE OF BURIAL Oct 4 1930
20. UNDERTAKER Cracraft Miller ADDRESS Jackson Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATE BOARD OF HEALTH WITH CHANGING INSTRUCTIONS THIS IS A PERMANENT RECORD

