

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.

MAR 2 1934

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

Do not use this space.

6858

**PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Primary Registration District No. **1003**

Registered No. **1713**

City **St. Louis, Mo.** (No. **3403, St. Vincent Av.**) St. .... Ward)

**2. FULL NAME**

**Dora Bauer Stroup**

(a) Residence, No. **3403, St. Vincent Av. 17** Ward.

(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 MEDICAL CERTIFICATE OF DEATH**

3. SEX <i>female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Robert E. Stroup</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>July 18-1869</i>		
7. AGE	YEARS <i>64</i>	MONTHS <i>6</i>
	DAYS <i>29</i>	If LESS than 1 day, ..... hrs. or ..... min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housewife</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>11</i>		
10. Date deceased last worked at this occupation (month and year).....		11. Total time (years) spent in this occupation.....

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *February 16, 1934*

22. I HEREBY CERTIFY That I attended deceased from *Feb 15, 1934* to *Feb 16, 1934*

I last saw h. *fr.* alive on *Feb 16, 1934*. Death is said to have occurred on the date stated above, at *1:50 pm*.

The principal cause of death and related causes of importance were as follows:  
*Cerebral haemorrhage*

Other contributory causes of importance:  
*Arteriosclerosis*  
*Arterial hypertension*

Date of onset

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Michigan</i>
	13. NAME <i>Frank Laurer</i>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Michigan</i>
	15. MAIDEN NAME <i>Julia E. Matthews</i>
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Michigan</i>
	17. INFORMANT <i>Mr. Robert E. Stroup</i> (ADDRESS) <i>3403 St. Vincent Av.</i>
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>St. Matthews Cem.</i> DATE <i>February 19, 1934</i>	
19. UNDERTAKER <i>E. J. Schur</i> (ADDRESS) <i>3125 Lafayette Av.</i>	
20. FILED <i>G. J. Bredick</i> Registrar.	

Name of operation *X* Date of .....

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *no* Date of injury....., 19.....  
Where did injury occur? *X* (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. *X*

Manner of injury *X*  
Nature of injury *X*

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify.....  
(Signed) *Kenneth J. Brookes*, M. D.  
(Address) *1656 Grand*

THIS IS A PERMANENT RECORD

