

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

Do not use this space.

MAY 31 1937

17431

1. PLACE OF DEATH

County *St Clair*
Township *Appleton*
City (No.) (No.) St. Ward

Registration District No. *761 5000*
Primary Registration District No. *44 56*

File No.
Registered No.

2. FULL NAME

Mary Electa 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 <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>W F Stroup</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug - 8 - 1864</i>		
7. AGE	YEARS	MONTHS
	<i>77</i>	<i>9</i>
	DAYS	
	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housekeeping</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 8* 19*36*
22. I HEREBY CERTIFY, That I attended deceased from *April 30* 19*36*, to *May 8* 19*36*
I last saw him alive on *May 1* 19*36* Death is said to have occurred on the date stated above, at *6 a. m.*

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

Chronic Myocarditis

Other contributory causes of importance:

Asthma

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify

(Signed) *R. L. Hanson* M. D.
(Address) *Appleton City, Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME *William Kenicutt*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New York*

15. MAIDEN NAME *Joanna Leach*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

17. INFORMANT *W F Stroup*
(ADDRESS) *Appleton City, Mo*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Appleton City, Mo* DATE *May - 9 - 37*

19. UNDERTAKER *Frank Leach*
(ADDRESS) *Appleton City, Mo*

20. FILED *May 6* 19*37* *R. A. Kenney*
Registrar

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.

