

FILED AUG 13 1945

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 209

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southern Mrs. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Girardeau

(c) City or town Cape Girardeau Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1015 Hawthorn St
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME EARNEST LEE STRODER

3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 1 - 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days _____ If less than one day hr. _____ min. _____

9. Birthplace Cape Girardeau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name John Paul Stroder

13. Birthplace Whitewater Mo
(City, town, or county) (State or foreign country)

14. Maiden name Virginia Walker

15. Birthplace Boonville Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. B. Walker

(b) Address Delta Mo.

17. (a) Burial (b) Date thereof July 4 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stroder Co. - Grange Mo

18. (a) Signature of funeral director W. H. Phillips

(b) Address W. H. Phillips

19. (a) 7-9-45 (b) W. H. Phillips
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 3 year 1945 hour 3 minute p.m.

21. I hereby certify that I attended the deceased from 7-1-45 to 7-3-45
that I last saw him alive on 7-3-45 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhagic disease of the new born

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations ✓ Of autopsy ✓

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? ✓ (Specify type of place) (e) Means of injury _____

23. Signature Allegan M. Estes (M. D. or other) _____
Address Jackson Mo. Date signed 7-5-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 4
District File Number 845-977
Date Filed 8-10-45

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.....

....., Registered Apprentice No.

working under my personal supervision.

Not Embalmed

Signed *[Signature]*

Licensed Embalmer No.

P. O. Address *[Signature]*

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