

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **40236**  
Registrar's No. **10893**

FILED DEC 6 1947  
Registration District No. **318**

Primary Registration District No. ....

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

1. PLACE OF DEATH:  
(a) County **St. Louis mo.**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **2110 Clark Ave 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **15 yrs**  
In this community **15 yrs**  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Emile Stroud**  
3. (b) If veteran, name war: **None**  
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **negro**  
6. (a) Single, widowed, married, divorced **married**  
(b) Name of husband or wife **James Stroud**  
6. (c) Age of husband or wife if alive **14 - 1900**  
years (Day) (Year)

8. AGE: Years **46** Months **11** Days **8**  
If less than one day hr. min.

9. Birthplace **Miss**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Domestic**

MOTHER FATHER  
11. Industry or business  
12. Name **Sam Carter**  
13. Birthplace **Miss**  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **Miss**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Naval Ingram**  
(b) Address **2110 Clark Ave**  
17. (a) **Burial** (b) Date thereof **11-29-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Walter Ross**  
(b) Address **3644 Finney Ave**  
19. (a) **NOV 28 1947** (b) **J. F. Bedeck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2110 Clark Ave 9**  
**22** (If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **NOV** day **23** year **1947** hour **5:00** minute **0** M.  
21. I hereby certify that I attended the deceased from **Sept 20** 1947 to **NOV 23** 1947  
that I last saw her alive on **Nov 21** 1947 and that death occurred on the date and hour stated above.  
Duration

Immediate cause of death  
**Mitral incompetence** **2 yrs**  
**Exophthalmic Goiter** **3 yrs**  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
Underline the cause of which death should be charged statistically.

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?.....  
(Specify type of place)  
While at work?..... (e) Means of injury.....  
23. Signature **J. F. Bedeck** (M. D. or other) **0**  
Address **302 E. Jefferson** Date signed **11/25/47**

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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.

Signed.....

*Louis V. Atkins*

Licensed Embalmer No. ....

*2842*

P. O. Address .....

*3644 Finney Ave*

**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.