No. 2
2-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28772

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 282

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1506 N. Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Lifetime (approx.) (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 1506 N Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Addie L. Stroup
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Noah Stroup
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 15 (Day) 1866 (Year)

8. AGE: Years 82 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Macon Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Calvin Cox
13. Birthplace (City, town, or county) Tenn. (State or foreign country)
MOTHER
14. Maiden name Sarah Vansickle
15. Birthplace (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Noah Hollway
(b) Address Kirksville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/1948 (Month) (Day) (Year)
(c) Place: burial or cremation Novinger Mo
18. (a) Signature of funeral director Albert Skinner
(b) Address Macon, Mo.
19. (a) Oct 2nd '48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29 year 1948 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from Sept 28, 1948 to Sept 29, 1948; that I last saw him alive on Sept 29, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia & medullary failure — Duration: 3 days
Due to: Thrombotic encephalomalacia?
Due to: Arteriosclerosis (Generalized) years
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
80 B

PHYSICIAN
Underline the cause to 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 2

23. Signature M. T. Gutensohn (M.D. or other) DO
Address Kirksville, Mo Date signed 9-30-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-48-1728
Date Filed OCT 5 1948

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 Albert Hunter

Licensed Embalmer No. 757

P. O. Address Macon Mo

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.