

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38874  
2659  
Registrar's No. \_\_\_\_\_

FILED DEC 4 1948  
Registration District No. 2063

Primary Registration District No. 2063

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

1. PLACE OF DEATH:  
(a) County ST. Louis  
(b) City or town CLAYTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST. Louis Co. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_  
years, months or days) M.

3. (a) PRINT FULL NAME JAMES A. STROUD  
3. (b) If veteran, name war no  
3. (c) Social Security No. 043-07-9248

4. Sex MALE  
5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(b) Name of husband or wife Maude Stroud  
7. Birth date of deceased July 19 1863  
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 25  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Manleyville, Tennessee  
(City, town, or county) (State or foreign country)

10. Usual occupation retired salesman

11. Industry or business Ramsey Mfg. Co.

MOTHER FATHER { 12. Name Stroud  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Morris  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Eldon E. Blust  
(b) Address 6935 Florian Ave.

17. (a) removal (b) Date thereof 11/17/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Litchfield, Illinois

18. (a) Signature of funeral director C.R. Lupton & Sons  
(b) Address 7233 Delmar Blvd.

19. (a) 11-13-48 (b) James A. Stroud  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(e) State Missouri (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6454 Alamo  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14  
year 1948 hour 4 minute 40 P. M.  
21. I hereby certify that I attended the deceased from 11-13  
1948, to 11-14, 1948  
that I last saw him alive on 11-14, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
natural causes - as  
combination of below:  
Due to dehydration, azotemia,  
urinary tract infection,  
Due to generalized atherosclerosis  
malnutrition, peripheral hypoxia  
Other conditions of prostate, fecal impaction  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations 1376  
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 J. A. Zojovic (M. D. or other) M.P.  
Address 201 Brentwood Date signed 11/14/48

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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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.**