

FILED JUL 8 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18436**

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4172 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY Dekalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stewartsville		b. COUNTY Dekalb	
c. LENGTH OF STAY (in this place) 15 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stewartsville	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) ##### Albert	c. (Last) Stroud	4. DATE OF DEATH (Month) (Day) (Year)
				6/25/54

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 11, 1877	9. AGE (in years last birthday) 77	IF UNDER 1 YEAR	IF UNDER 1 HR.
					Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Buchanan Co. Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Joshua Stroud	13b. MOTHER'S MAIDEN NAME Mary *****	14. NAME OF HUSBAND OR WIFE Sarah E. Stroud
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or both) ***	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Delmas F. Stroud	ADDRESS St Joseph, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 44hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1954, to June 25, 1954, that I last saw the deceased alive on June 25, 1954, and that death occurred at 2:00a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joe Suderman D.O.	23b. ADDRESS Stewartsville, Mo	23c. DATE SIGNED 6-28-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/29/54	24c. NAME OF CEMETERY OR CREMATORY Freeman Chapel	24d. LOCATION (City, town, or county) (State) Buchanan Co Mo.
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DATE REC'D BY LOCAL REG. 6-30-54	REGISTRAR'S SIGNATURE Rescoe D. ...	25. FUNERAL DIRECTOR'S SIGNATURE W. E. Summerfield	ADDRESS Stewartsville Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed W. E. Cunningham

Licensed Embalmer No. 3007

P. O. Address Stewartville, 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.