

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34169**
Registrar's No. **4921**

FILED NOV 10 1954

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| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. <u>4921</u> | | |
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) Kansas City, | | | c. LENGTH OF STAY (in this place) 2.8 yrs | | c. CITY OR TOWN Kansas City | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital | | | | STREET ADDRESS (If rural, give location) 2419 Cherry | | 3428 2 | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Eugene | | | b. (Middle) Richard | | c. (Last) Stroud | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 21 1954 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Dec. 19 1914 | 9. AGE (In years last birthday) 39 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Arkansas | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME John Stroud | | | 13b. MOTHER'S MAIDEN NAME Minnie Ross | | | 14. NAME OF HUSBAND OR WIFE Mary Alice Stroud | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War No 2- | | | 16. SOCIAL SECURITY NO. 487-10-8679 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Stroud 2419 Cherry K.C.Mo. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bullet Wound Chest | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 9195 43 | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 123 (STATE) Kansas City Jackson Mo | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-21-54 | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Storekeeper Chertney at School | | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:15 P. , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE Hugh H. Owens | | | 23b. ADDRESS 1034 Pratts Apts. | | 23c. DATE SIGNED 10-23-54 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Oct. 23 1954 | | 24c. NAME OF CEMETERY OR CREMATORY Floral Hill Cemetery | | 24d. LOCATION (City, town, or county) (State) Kansas City, Missouri | | |
| DATE REC'D BY LOCAL REG 10-23-54 | | REGISTRAR'S SIGNATURE Neva Marshall | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs C.L.Forster Funeral Home Kas. City, Mo. | | | |

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.....
Signature of Student Embalmer

Signed.....

Raymond E. Steman

Licensed Embalmer No. 426

P. O. Address K.C. 27

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.