

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

= 62-032948

7579

STATE FILE NUMBER

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Registration District No. **318** Primary Registration District **1003** Registrar's No. _____

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|---|--|--|-------|---|--|---|--|---|------|-----------------|--|--|--|---------------------------|-----|------|--|------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | | | | | | | | | | | |
| | | St. Louis | | | | Missouri | | | | | | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | St. Louis City Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| | | | | | | 1722 Waverly Pl. | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | | Middle | | | Last | | | 4. DATE OF DEATH Month | | | Day | | | Year | | |
| Lisa Louann Stroup (also known as) Lisa Louann Pender | | | | | | | | | | | | August | | | 2, | | | 1962 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR | | | | | | | | |
| Female | | White | | | | 7/4/1961 | | 1 | | Months | | Days | | Hours | | Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and state or country) | | | | 12. CITIZEN OF WHAT COUNTRY | | | | | | | | |
| None | | | | | | | | Walnut Ridge, Arkansas | | | | U.S. | | | | | | | | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | | | | | | |
| Joseph Stroup | | | | Nancy Buchanan | | | | None | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | | | | | | | | |
| No | | | | None | | | | Joseph Stroup, 1722 Waverly Pl. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | | | | |
| Subdural hemorrhage subsequent to fracture skull, suffered in fall at home on July 25, 1962. | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | |
| DUE TO (b) | | | | | | | | | | | | | | | | | | | | |
| accident 904.0-21 | | | | | | | | | | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | | | | | | | | | | | |
| | | | | see above | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | Month, Day, Year | | | | | | | | | | | | | | | | | | |
| | | 7-25-62 | | | | | | | | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE | | | | | | | | | | | | |
| | | 23 | | St. Louis, Mo | | | | | | | | | | | | | | | | |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | | | 22b. ADDRESS | | | | | | 22c. DATE SIGNED | | | | | | | | |
| Paul J. Simon Deputy Coroner | | | | | | 1308 Clark | | | | | | 8/2/62 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) (State) | | | | | | | | | | | | |
| Removal | | 8-3-62 | | | | | | Walnut Ridge, Arkansas | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | | | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | | | | |
| Albert H. Honpe, Inc., 4700 Washington Blvd. | | | | | | | | | | | | AUG 2 1962 | | Loan Smith, M.D. | | | | | | |

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 *Philip J. Haines*

Licensed Embalmer No. 4108

P. O. Address *Harris*

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.