S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 5 1947

Registration District No. ____

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3033

State File No. 17932

Registrar's No. ____

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community entire life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. King St. Hayes addition
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME SARAH JANe STroup
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Chas. Henry Stroup
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased June (Month) 15 (Day) 1860 (Year)

8. AGE: Years 86 | Months 11 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Indianapolis (City, town, or county) Ind. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____

MOTHER
12. Name Jake Gresson
13. Birthplace unknown (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Matilda (unknown)
15. Birthplace North Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hazel Eoff
(b) Address Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemetery
18. (a) Signature of funeral director W.E. Holman
(b) Address Lebanon, Mo.
19. (a) May 31, 1947 (Date received by local registrar) (b) Orr Brandenburger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1947 hour 11 minute ____ P.M.

21. I hereby certify that I attended the deceased from 17th May, 1947 to 17th May, 1947; that I last saw her alive on 17 May, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cholaemia	
Due to myocarditis &	
myocardial degeneration	
Due to Cerebral Hemorrhage	5 yrs
Due to ____	
Other conditions Senility (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN

Underline the cause of 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 ____

23. Signature J. Bumemer (M. D. or other) M.D.
Address Lebanon Mo Date signed 1-21-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Received 6/4/47

Laclede County Health Unit

File No. 6/47-94

Date Filed 6/4/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.