

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

8570  
Do not use this space.

APR 12 1939

**1. PLACE OF DEATH**

(a) County.....<sup>2</sup> Registration District No.....<sup>791</sup>  
 (b) Township.....<sup>1</sup> Primary Registration District No.....<sup>1003</sup>  
 (c) City St. Louis (d) Street No. 5527 Lansdowne St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **2335**

**2. PRINT FULL NAME** Virginia Strong

(a) Residence, No. 5527 Lansdowne St. 14 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elam Marion Strong

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 16, 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	78	6	25	

OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>
	10. Date deceased last worked at this occupation (month and year).....
	11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN)..... Jackson, Mo.  
 (STATE OR COUNTRY)

13. NAME Mastin Gladish  
 14. BIRTHPLACE (CITY OR TOWN)..... Kentucky  
 (STATE OR COUNTRY)

15. MAIDEN NAME Mrs. Sandiser  
 16. BIRTHPLACE (CITY OR TOWN)..... Kentucky  
 (STATE OR COUNTRY)

17. INFORMANT Vivian Strong  
 (ADDRESS) 5527 Lansdowne

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Jackson, Mo. DATE March 12, 39

19. FUNERAL DIRECTOR (NAME) J. L. Ziegenhein & Sons  
 (ADDRESS) 7027 Gravois Ave.

20. FILED AR 11-1939  
J. B. Buech  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 10, 1939 to Mar 11, 1939  
 I last saw him alive on Mar 11, 1939. Death is said to have occurred on the date stated above, at 12:20 P.M.  
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage.

Date of onset 3-10-39

Other contributory causes of importance:

Arteriosclerosis  
Hypertension

Name of operation none Date of.....  
 What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury....., 19.....  
 Where did injury occur?.....  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify.....  
 (Signed) Fabian J. Buech M. D.  
 (Address) 6402 N. Morganford

**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 Clarence P Kidwell

Licensed Embalmer No. 3877

P. O. Address 6937<sup>a</sup> Gravo

**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, above space should be left blank.**