

FILED JAN 10 1949

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1138

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
O'REILLY VA HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 73 days (Specify whether  
In this community 73 days years, months or days)

3. (a) PRINT FULL NAME STEVE STRONG

3. (b) If veteran, name war WW I 3. (c) Social Security No. Unknown

4. Sex male 2 5. Color or race negro 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased April 3, 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>8</u>	<u>29</u>	hr. min.

9. Birthplace Allenville Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

11. Industry or business ---

12. Name Steve Strong 9

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Louise Abernatha 11

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Strong

(b) Address 2721 Thomas St., St. Louis, Mo.

17. (c) Removal (b) Date thereof 1/3/49  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau, Missouri

18. (a) Signature of funeral director Gorman-Scharpf Funeral Home (Specify type of place)

(b) Address O'Reilly VAH, Springfield, Mo. (c) Means of injury ---

19. (a) 1-2-49 (b) W. H. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County Madison 99  
(c) City or town ALTON (If outside city or town limits, write "RURAL")  
(d) Street No. 712 Belle St. (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1  
year 1949 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from October 20, 1948, to January 1, 1949  
that I last saw him alive on January 1, 1949  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary far advanced, active. Duration ---

Due to ---

Due to ---

Other conditions (Include pregnancy within 3 months of death) ---

Major findings:  
Of operations ---  
Of autopsy ---

PHYSICIAN  
Underline the cause to 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) (e) Means of injury ---

23. Signature L. FISHBURN, M.D. (M. D. or other) ---

Address O'Reilly VAH, Springfield, Mo. Date signed 1-1-49

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

MOTHER FATHER

JAN 26 1949

JAN 18 1949

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

*Gene C. Hunter*

, Registered Apprentice No.

*291*

working under my personal supervision.

Signed

*Loachin Gorman*

Licensed Embalmer No.

*3177*

P. O. Address

*Springfield, 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.