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

Do not use this space.

8669

1. PLACE OF DEATH

County..... Registration District No. 791 10003

Township..... Primary Registration District No.....

City St. Louis (No. City Hospital St. ..... Ward)

File No. 8342

Registered No. .....

2. FULL NAME Albert Strong.

(a) Residence. No. 5806 Victoria av. St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hattie Strong,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1858-3-20

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	10	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer,

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Jordan Strong

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) ?

14. INFORMANT Robert Strubbe
(Address) 4296 N. Euclid av.

15. FILED ..... 19..... Max O. Stifler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Febuary 19, 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-8-, 1929, to Feb. 19, 1929, that I last saw h. im. alive on 2-16-, 1929, and that death occurred, on the date stated above, at 10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Hart Failure
92.A

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? .....
IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Louis Gist, M. D.

2/19/29 (Address) 3500 N. Grand av.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Leasburg, Mo.	2/21/29

20. UNDERTAKER Robert Strubbe ADDRESS 4296 N. Euclid av.

237 2 31 31