

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

1. PLACE OF DEATH

County Cass
Township Dayton
City Dayton (No. _____ St. _____ Ward _____)

Registration District No. 161
Primary Registration District No. 5226

File No. 29549
Registered No. 8

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 Mary A Kimberlin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
62 4 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Henry Co
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm J Armstrong

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Johnson Co Mo
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Diana Blewett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Henry Co Mo
(STATE OR COUNTRY) _____

14. INFORMANT Robt Armstrong
(Address) Garden City Mo

15. FILED 10-30 1923 Mrs C S Dodd
Deft REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 19 23

17. I HEREBY CERTIFY That I attended deceased from Sept 5 19 23 to Oct 30 19 23
that I last saw him/her alive on Oct 30 19 23, and that death occurred, on the date stated above, at 12 40 PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
12 12 (duration) _____ yrs. _____ mos. 6 hrs
CONTRIBUTORY (SECONDARY) nephritis
(duration) 2 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Casper S Dodd M. D.
, 19 _____ (Address) _____

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Dayton Cemetery DATE OF BURIAL Oct 31 1923

20. UNDERTAKER Arnold Bros, Creighton Mo ADDRESS _____

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

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 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Ward.....

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(a) Residence, No..... St..... Ward.....
 (Usual place of abode)
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3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR WIFE OF		
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7. AGE	YEARS	MONTHS
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(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED....., 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....

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CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

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(Signed).....

, 19 (Address)

M. D

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DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19