

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

Do not use this space.

16057

PLACE OF DEATH

County Candolph
Township mobely
City mobely (No. 818 Fremontade)

Registration District No. 735
Primary Registration District No. 3034

File No. _____
Registered No. 91 St. 2nd Ward

2. FULL NAME

Jack Owings Armstrong
(a) Residence. No. 818 Fremontade St. 2nd Ward.
(Usual place of abode)

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 m 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11th 1917

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 10 9

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Harold Armstrong

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

12. MAIDEN NAME OF MOTHER Martha Owings

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

14. INFORMANT Harold Armstrong
(Address) mobely Mo

15. FILED 3/14 1927 Thos. S. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10th 1927

17. I HEREBY CERTIFY, That I attended deceased from May 10th 1927 to May 10th 1927, that I last saw him alive on May 10th 1927, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dilatation heart

875
750 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chorea (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

19. Did an OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? hemiokeel

(Signed) _____, M. D.

5-11th 1927 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL mobely, Mo DATE OF BURIAL 5-11th 1927

20. UNDERTAKER Mahow and Low ADDRESS mobely Mo

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.

29 1927

