

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

Do not use this space.

16524

**1. PLACE OF DEATH**

County Clay  
Township North  
City Excelsior Springs

Registration District No. 198  
Primary Registration District No. 3011

File No. \_\_\_\_\_  
Registered No. 46  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** William Hough Armstrong

(a) Residence. No. Excelsior Sanitarium St., \_\_\_\_\_ Ward Cedar Rapids, Iowa  
(Usual place of abode (if nonresident give city or town and State))

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**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) Elise Armstrong

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
69 | 10 | 22 | = |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Grocery  
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant  
(c) Name of employer no

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER William Armstrong

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

12. MAIDEN NAME OF MOTHER Phobia Hough

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

14. INFORMANT Elta U. Sweet  
(Address) Columbus, Ohio

15. FILED 5/1, 28 910 Craun  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12, 1928

17. I HEREBY CERTIFY That I attended deceased from April 18, 1928 to May 10, 1928 that I last saw him alive on May 12, 1928 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Influenza pneumonia  
131  
11A

CONTRIBUTORY (SECONDARY) Pneumonia  
(duration) 2-3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH. no

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) G. C. Pollock, M. D.  
, 19 (Address) Excelsior Springs, Mo.

\*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 Cedar Rapids Iowa DATE OF BURIAL not known

20. UNDERTAKER H. T. Hofer ADDRESS Excelsior Springs

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.

