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

Do not use this space.

1307

1. PLACE OF DEATH
County Howard Registration District No. 878
Township — Primary Registration District No. 4922
City Fayette (No. — St. — Ward) File No. — Registered No. 2

2. FULL NAME John W. Armstrong
(a) Residence. No. — St., — 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 Anna M. Armstrong.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/29/1854

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
74	6	25	

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) —
(STATE OR COUNTRY) Missouri.

PARENTS

10. NAME OF FATHER Abner E. Armstrong.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Susan Nolls.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) Kentucky.

14. INFORMANT Earl Hyatt
(Address) Fayette, Mo.

15. FILED 1-30, 19 29 V. A. Bonham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/24 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 19 28 to Jan-24, 1929, that I last saw h. alive on Jan. 23, 1929, and that death occurred, on the date stated above, at 2 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage
Dec. 1927.
Fracture of R Hip Jan 3-1929
Arteriosclerosis (duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (SECONDARY) Fractured Hip
(duration) — yrs. 20 mos. — ds.

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? Clinical findings
(Signed) T. B. Richards, M. D
, 19 (Address) Fayette 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: City Cemetary — DATE OF BURIAL: 1/26 29 19

20. UNDERTAKER: Guy T. Halley. — ADDRESS: Fayette, Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Howard Registration District No. 378 File No.
Township Primary Registration District No. 3333 Registered No.
City Fayette (No. , St. Ward)

2. FULL NAME John W Armstrong
(a) Residence. No. St., 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)
M.	W.	M.

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

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

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

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)
(STATE OR COUNTRY)

PARENTS
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 Jan 30. 1929 V. O. Bonham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 24 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fractured Hip. Fall from Porch
(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?
(Signed) , 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

185

2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in such terms, so that it may be properly classified. Full statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

S-1307