

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

Do not use this space.

30057

1. PLACE OF DEATH

County Boone

Registration District No. 73

Township Columbia

Primary Registration District No. 3006

City Columbia

File No. 228

Registered No. _____

St. _____ Ward) _____

2. FULL NAME

(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

Female

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

H. L. Armstrong

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

Nov. 26 - 1887

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

41

9

20

8. OCCUPATION OF DECEASED

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

Housewife

(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)

Boone Co.,

Missouri

10. NAME OF FATHER

Walter M. Berry

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Boone Co., Mo.

12. MAIDEN NAME OF MOTHER

Amanda Fleming

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Howard Co.,

Missouri

14.

INFORMANT

(Address)

H. L. Armstrong

15.

FILED

9-25-29 Beatrice Grubbs

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-16 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis.

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

CONTRIBUTORY (SECONDARY)

Chronic Nephritis.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF June

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Robert H. Simpson, 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

Memorial Cemetery

9-18 1929

20. UNDERTAKER

ADDRESS

B. F. Baker

Columbia

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.

