

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

Do not use this space.

14581

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **3943**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **Baby Armstrong**
(Usual place of abode) **4380 St. Louis Ave. #11** Ward. **11**
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX **male**
4. COLOR OR RACE **Cal**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-2-30**
17. I HEREBY CERTIFY, That I attended deceased from **4/1** 19**30**
that I last saw h. **in** 19**30**, to **4/2** alive on **4/2** 19**30** and that death occurred, on the date stated above, at **5:58** m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **4-1-30**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, **14** hrs. or **50** min.
Premature

Premature
159 (duration) **16** yrs. mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **mil**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

CONTRIBUTORY (SECONDARY) **1610**
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **mo**

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER **Wm Armstrong**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **unknown**
12. MAIDEN NAME OF MOTHER **Edna Riddle**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY?.....

14. INFORMANT **A. Glendon Heath**
(Address) **City Hosp #2**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **A. H. Mathers, M. D.**
4/5, 19**30** (Address) **City Hosp #2**

15. FILED **APR 27 1930**
REGISTRAR **Clayton**

*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
4-24-1930

20. UNDERTAKER ADDRESS
Clayton 3945 Stanton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

63

