

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

Do not use this space.

17188

1. PLACE OF DEATH

91 County Boyer
Township Shelby
City _____ (No. _____)

Registration District No. 751
Primary Registration District No. 5990

File No. 415
Registered No. 38
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

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

July 5 - 1928

7. AGE

YEARS

MONTHS

DAYS

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

3

7

7

8. OCCUPATION OF DECEASED

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

child at

(b) General nature of industry, business, or establishment in which employed (or employer).

home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Poplar Bluff,

(STATE OR COUNTRY)

Butler Co. Mo.

10. NAME OF FATHER

Herbert M. Armstrong

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Advance

(STATE OR COUNTRY)

Stottard Co. Mo.

12. MAIDEN NAME OF MOTHER

Myrtle M. Armstrong

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

unknown

(STATE OR COUNTRY)

Texas

14.

INFORMANT

H. M. Armstrong

(Address)

Naylor, Mo.

15.

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 2 1932

17.

I HEREBY CERTIFY, That I attended deceased from April 15, 1932, to May 2, 1932.
that I last saw him alive on May 1, 1932, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia

9
107 A

(duration) _____ yrs. _____ mos. 20 ds.

CONTRIBUTORY (SECONDARY)

Pertussis

(duration) _____ yrs. 1 mos. 5 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

(Signed)

H. E. White

M. D.

87 19 32 (Address) Naylor 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

DATE OF BURIAL

Friendship, Ark.

April 3 1932

20. UNDERTAKER

ADDRESS

Gish Undert. Co.

Naylor, 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.

CAUSE

M.B.—Rae

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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 Repley
 Township Thomson
 City St. Louis (No.)

Registration District No. 73-1
 Primary Registration District No. 5990

File No. 415-
 Registered No. 38
 St. Ward

2. FULL NAME

Helma Levene Armstrong

(a) Residence, No. St. 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 <u>F</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (<i>write the word</i>) <u>S</u>	
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.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.				
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.				
	10. Date deceased last worked at this occupation (month and year)				
11. Total time (years) spent in this occupation					
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)					
FATHER	13. NAME				
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
MOTHER	15. MAIDEN NAME				
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)					
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19					
19. UNDERTAKER (ADDRESS)					
20. FILED <u>July 17 1932</u> <u>St. Louis</u> Registrar					

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 7 1932

22. I HEREBY CERTIFY, That I attended deceased from

to 19

I last saw h. alive on 19

Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

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

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