

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.

APR 20 1933
201933

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

Do not use this space.
29682

1. PLACE OF DEATH

County Jackson Registration District No. 099
Township Low Primary Registration District No. 7007
City R. C. Mo. (No. Mercy Hospital) St. _____ Ward _____

File No. _____
Registered No. 3606 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. 444 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Child</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Child</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11-30-32</u>		
7. AGE YEARS	MONTHS	DAYS
	<u>10</u>	<u>9</u>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Child</u>	
	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) <u>R. C. Mo.</u>		
FATHER	13. NAME <u>Ray Armstrong</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Colo.</u>	
MOTHER	15. MAIDEN NAME <u>Leara Johnson</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	
17. INFORMANT <u>Ray Armstrong</u> (ADDRESS) <u>302 - 9 Ave.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Liberty Mo.</u> DATE <u>Sept 13</u> 19 <u>33</u>		
19. UNDERTAKER <u>Robert Henderson</u> (ADDRESS) <u>4139 - E - 15 - St.</u>		
20. FILED <u>9-12-33</u> <u>M. M. Crowe</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 11 1933

22. I HEREBY CERTIFY, That I attended deceased from 8-26-33, 19____, to 9-11-33, 19____.
I last saw h. 11 A alive on 9-11-33, 19____. Death is said to have occurred on the date stated above, at 12 noon.
The principal cause of death and related causes of importance were as follows:
Gastro Enteritis
119B
HAD
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) Mercy H. Hoops M. D.
(Address) 129 Waller

