

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

Do not use this space.

File No. **34095**
Registered No. **3** Ward

1. PLACE OF DEATH
County **Butte** Registration District No. **689**
Township **Buffalo** Primary Registration District No. **3033**
City **Louisiana** (No. **1204** St. **3** Ward **3**)
2. FULL NAME **Anna Belle Jones Armstrong**
(a) Residence, No. **1204** St. **3** Ward **3**
(Usual place of abode)
Length of residence in city or town where death occurred **30** 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 African	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Joseph Armstrong (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 16 - 1902		
7. AGE	YEARS	MONTHS
	30	11
		DAYS
		15
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
Housekeeper		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
None		
10. Date deceased last worked at this occupation (month and year)		
None		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana Mo		
13. NAME Paul Jones		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La Mo		
15. MAIDEN NAME Mollie Allison		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La Mo		
17. INFORMANT Mollie Allison (ADDRESS) Louisiana Mo		
18. BURIAL, CREMATION, OR REMOVAL PLACE Wrens River DATE Nov 3		
19. UNDERTAKER W. F. Buda (ADDRESS) Louisiana Mo		
20. FILED 11/23 19 33 F. H. Taylor Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 31** 19**33**

22. I HEREBY CERTIFY, That I attended deceased from **10 - 30** 19**33** 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:
Obstruction of
460 bowel
Date of onset

Other contributory causes of importance:
None

Name of operation **None** Date of **None**
What test confirmed diagnosis? **ill** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **None** Date of injury **None**, 19**33**
Where did injury occur? **None**
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **None**
Nature of injury **None**

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **None**
(Signed) **W. F. Buda**, M. D.
(Address) **Louisiana Mo**

NOV 10 1933

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.

**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 Pike
Township Linn
City Linn (No.)

Registration District No. 689
Primary Registration District No. 3033

File No.
Registered No. 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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. 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

19 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 31 1933

22. I HEREBY CERTIFY, That I attended deceased from to 19

I last saw him 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:

Heart failure
secondary
Edema
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)

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 COMPLETED AS PRESCRIBED BY LAW.

5-34095