

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.

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

OCT 12 1939

32769

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township Lebanon Primary Registration District No. 56-947-67
(c) City Lebanon or (d) Street No. Wallace Hospital Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 652 William C Armstrong St. []
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lula Ann Armstrong

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 27 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 4 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as 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) Clark Co Mo

FATHER 13. NAME Chas Armstrong 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York 7

MOTHER 15. MAIDEN NAME Anna Sage

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) Earl Armstrong
Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Union DATE 9/21/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W.E. Holman
Lebanon Mo

20. FILED 22 1939 G. M. Coombs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/17/39 19

22. I HEREBY CERTIFY, That I attended deceased from Sept 16 1939, to Sept 17 1939
I last saw him alive on Sept 17 1939. Death is said to have occurred on the date stated above, at 11:45 P.M.
The principal cause of death and related causes of importance were as follows:

Fractured Skull
10 yrs
Date of onset Sept 16-39

Other contributory causes of importance:

Name of operation none Date of Sept 16-39
What test confirmed diagnosis? Physical exam and there an autopsy no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury Sept 16-39
Where did injury occur? Highway #66 Lebanon Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury car accident
Nature of injury Fractured Skull

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) P. H. H. H. M. D.
(Address) Lebanon Mo

RECEIVED

District Health Officer No. 7,

District File Number 7-39-139

Date Filed 10-9-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Myself

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

W.E. Halman

Licensed Embalmer No.....

4107

P. O. Address.....

Lubauer Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.