DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42660

Registration District No. 79 — Primary Registration District No. 5036 — Registrar's No.

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.

1. PLACE OF DEATH:

(a) County: Gentry

(b) City or town: Darlington Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Putnam

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: FLORA AMELIA ARMONTROUT

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex: F | 5. Color or race: W | 6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: 6 (Month) 22 (Day) 1854 (Year)

8. AGE: Years: 85 | Months: 5 | Days: 22 | If less than one day ____ hr. ____ min.

9. Birthplace: VIRGINIA (City, town, or county) ____ (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business ____

MOTHER FATHER

12. Name: PETER

13. Birthplace: VIRGINIA (City, town, or county) ____ (State or foreign country)

14. Maiden name: UK

15. Birthplace: UK (City, town, or county) ____ (State or foreign country)

16. (a) Informant's own signature: R L Armontrout

(b) Address ____

17. (a) Centralia Mo (Burial, cremation, or removal) (b) Date thereof 12 16 39 (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director: McNeal Dorsey

(b) Address: Centralia Mo

19. (a) 12/16-1939 (Date received local registrar) (b) A E Booth (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14th year 1939 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from Dec 1st, 1939 to Dec 14, 1939 that I last saw h[illegible] alive on Dec 14, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremic Myocarditis	7
Due to: Senility	
Due to: ?	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other)

Address Centralia Mo Date signed 12/15/39

(Licensed Embalmer's Statement on Reverse Side)

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~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed M J McDonald

Licensed Embalmer No. 2589

P. O. Address Centralia Mo

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

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