

Registration District No. 788

Primary Registration District No. 3020

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Jasper
 (b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
707 S. River 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 40 yrs.
years, months or days)

8. (a) PRINT FULL NAME KATHERINE ARMSTRONG

3. (b) If veteran, name war No 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife E. H. Armstrong 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased August 4, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace Michigan Town Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____
 { 12. Name Kaleb Smith
 18. Birthplace Indiana
(City, town, or county) (State or foreign country)
 14. Maiden name Louise Miller
 15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Della Herr
 (b) Address Carthage Mo.

17. (a) Burial (b) Date thereof Feb. 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Waters Cemetery

18. (a) Signature of funeral director J. W. K. Miller
 (b) Address Carthage Mo. 815

19. (a) Feb. 19, 1940 (b) E. G. McIntire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jasper
 (c) City or town Carthage
(If outside city or town limits, write "RURAL")
 (d) Street No. S 707 So River
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17th
 year 40 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from 2/13/40
 _____, 19____, to 2/17/40, 19____;
 that I last saw her alive on 2/16/40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Abscess Duration 14 days

Due to _____
 Due to _____

Other conditions Intermittent Heart Disease
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____
 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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature J. T. McQuinn (M. D. or other) M.D.
 Address 309 Grant Carthage Mo. Date signed 2/19/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

RECEIVED

District Health Officer No. 6,

District File Number 340-772

Date Filed MAR 9 1940

95132

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 Lucy Lure-Bucknell
Licensed Embalmer No. 2510

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **6940**

Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME **Katherine Armstrong**

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

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **13** If less than one year..... hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **17** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death **Submonary abscess**
(Etiology Undetermined)
Due to.....
Due to..... **95B**

Other conditions..... (Include pregnancy within 3 months of death)
Asterio sclerotic Heart
Major findings:
Of autopsy.....

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

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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **J. F. Mc New** (M. D. or other) **MD**
Address **Carthage Mo** Date signed.....

SUPPLEMENTARY

S-6940