

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21289**
Registrar's No. **695**

Registration District No. **85**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:

(a) County Burkhead
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2825 Reiner St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Burkhead
(c) City or town St Joseph, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2810 Sacramento
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29th
year 1940 hour 9:03 minute _____ M.

21. I hereby certify that I attended the deceased from
June 30th 1940 to _____ 19____;
that I last saw ~~the deceased~~
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Thrombosis
Duration _____

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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 B. L. Tedlock Coroner (M. D. or other) _____
Address King Hill Bldg Date signed 7/1/40

3. (a) PRINT FULL NAME Charlotte M. Armstrong

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

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

6. (b) Name of husband or wife John W. Armstrong 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 11th 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name W. W. Thompson

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

14. Maiden name Lepithia V. Wells

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

16. (a) Informant J. W. Armstrong

(b) Address 2810 Sacramento

17. (a) Burial (b) Date thereof July 1, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Park Cem.

18. (a) Signature of funeral director J. L. Brungley

(b) Address 2925 Mitchell St

19. (a) July 1, 1940 (b) B. L. Tedlock
(Date received local registrar) (Registrar's signature)

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

J. L. Armstrong

Licensed Embalmer No. 1946

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.