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.

S.S.No. ~~unknown (if one)~~ None

FILED OCT 12 1940

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

31736
Do not use this space.

1. PLACE OF DEATH
(a) County Clay 3
(b) Township or City Fishing River 1
(c) Excelsior Springs, Mo.
Registration District No. 198
Primary Registration District No. 3011
Registered No. 140
(d) Street No. Veterans Administration Facility St.
(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. 3 mos. 23 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William C. Armstrong
(a) Residence, No. Content, Montana St.
(Usual place of abode, if no street address, write county or city)
Content, Montana
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF (OR WIFE OF)~~: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 3, 1890
7. AGE: Years 50 | Months 8 | Days 5 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
9. Industry or business in which work was done, as saw mill, bank, etc. Farm
10. Date deceased last worked at this occupation (month and year) unknown
11. Total time (years) spent in this occupation unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Odessa, Mo. 0

FATHER
13. NAME William Armstrong 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? Tennessee 1

MOTHER
15. MAIDEN NAME Anna Carter
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? Virginia

17. INFORMANT (ADDRESS) Hospital records

18. ~~BURIAL, CREMATION, OR REMOVAL~~
PLACE Lockwood, Mo. DATE 9-9-40, 19..

19. FUNERAL DIRECTOR (NAME) Claude Prichard 80
(ADDRESS) Excelsior Springs, Mo.

20. FILED 9-9, 1940 Mrs Rea McCracken
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 8, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 16, 1940, to Sept. 8, 1940
I last saw him alive on Sept. 8, 1940. Death is said to have occurred on the date stated above, at 9:25 A.M.
The principal cause of death and related causes of importance were as follows:

Date of onset

Carcinoma of rectum with generalized carcinomatosis of abdomen and liver.

Other contributory causes of importance: --

46

Name of operation Paracentesis Date of 7-22-40
What test confirmed diagnosis? examination and observation Was there an autopsy? No

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. Unknown

(Signed) W. A. GERMAN, M.D., Clinical Director
(Address) Veterans Administration Facility
Excelsior Springs, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-9-40

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 Walter Barker, Registered Apprentice No. 228 working under my personal supervision.

Signed Claude Prichard

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs

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

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