

13-40
7-39
K23159

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38625**

Registration District No. **288** Primary Registration District No. **5406** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Dunklin**
(b) City or town **Rural** (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 **2** (Specify whether
In this community **Twenty four years** years, months or days)

3. (a) PRINT FULL NAME **John Luther Armstrong**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sarah Armstrong** 6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **May 25 1865** (Month) (Day) (Year)

8. AGE: Years **75** Months **5** Days **5** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Luther Armstrong**

13. Birthplace **Don't know** (City, town, or county) **See** (State or foreign country)

14. Maiden name **Don't know** (City, town, or county) **Don't know** (State or foreign country)

15. Birthplace **Don't know** (City, town, or county) **Don't know** (State or foreign country)

16. (a) Informant **Bill Armstrong**

(b) Address **Kennett Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-6-40** (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Ridge, Mo.**

18. (a) Signature of funeral director **Wm. H. Kern**

(b) Address **Kennett Mo.**

19. (a) **11-14-40** (Date received local registrar) (b) **Wm. H. Kern** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dunklin**
(c) City or town **Kennett R. 1** (If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **5** year **1940** hour **3** minute **20 a.m.**
21. I hereby certify that I attended the deceased from **10-31**, 19**40**, to **11-5-**, 19**40**
that I last saw him alive on **11-5-**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **CH - hypertension**
generalized atherosclerosis
Due to **arteriosclerosis**

Other conditions **1. Arterial fibrillation**
(Indicate pregnancy within 3 months of death)

Major findings: Of operations **4. 2. 11.**
Of autopsy _____

Duration
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? **261**
(Specify type of place) While at work? (e) Means of injury _____

23. Signature **Wm. H. Kern** (M. D. or other) **1**
Address **Kennett, Mo** Date signed **11-3-40**

RECEIVED

District Health Officer No. 2

District File Number 1240-182

Date Filed 12/12/40

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.