

FILED DEC 14 1942

STANDARD CERTIFICATE OF DEATH

37633

Registration District No. 274-240

Primary Registration District No. 4-0-634-388

State File No.

Registrar's No. 47

1. PLACE OF DEATH:

(a) County. *New Madrid*
(b) City or town. *Lilbourn, Mo*
(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. *6 mo* (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Chester Armstrong, Jr

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

4. Sex. *Male* 5. Color or race. *Black* 6. (a) Single, widowed, married, divorced. *Single*
6. (b) Name of husband or wife. *-* 6. (c) Age of husband or wife if alive. *-* years (Day) (Year)
7. Birth date of deceased. *Mar 3 1942*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 12 - hr. min.

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

10. Usual occupation. *none*

11. Industry or business.

12. Name. *Chester Armstrong*
13. Birthplace. *Oxford, Miss.* (City, town, or county) (State or foreign country)
14. Maiden name. *Sandra Smith*
15. Birthplace. *Oxford, Miss.* (City, town, or county) (State or foreign country)

16. (a) Informant. *Chester Armstrong*
(b) Address. *Lilbourn, Mo*
17. (a) *Burial* (b) Date thereof. *Mar 16 1942*
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. *Blossfield Cem*

18. (a) Signature of funeral director. *Sam Gray*
(b) Address. *Lilbourn, Mo*
19. (a) *12-7-42* (b) *Mo. J. L. Parrett*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. *Mo* (b) County. *New Madrid*
(c) City or town. *Lilbourn, Mo Rural*
(If outside city or town limits, write "RURAL")
(d) Street No. *-* (If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country. *-*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* day *15*
year *1942* hour *11* minute *45* a.m.
21. I hereby certify that I attended the deceased from *Dec 15* 19 *-* to *-* 19 *-*
that I last saw him alive on *-* 19 *-*
and that death occurred on the date and hour stated above.

Immediate cause of death. *unknown*
probably - Pneumonia
from history of case

Due to. *-*

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?
-

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

23. Signature. *E. E. Jones* (M. D. or other)
Address. *Lilbourn, Mo* Date signed. *3-15-42*

RECEIVED

District Health Office No. 2

District File Number 1242-168

Date Filed 12-11-42

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.

STANDARD CERTIFICATE OF DEATH

State File No. 37633
Registrar's No. 47

Registration District No. 240

Primary Registration District No. 4358

1. PLACE OF DEATH:

- (a) County New Madrid
(b) City or town Silbourn
(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 Chester Armstrong Jr.

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced _____

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

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace mo. (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 _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 19 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

- Immediate cause of death unknown Duration _____

- Due to Probably bronchial pneumonia

- 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)

- (b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

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

- Address _____ Date signed _____

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

SUPPLEMENTARY

