No. 2
-5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10310

FILED MAR 16 1943

Registration District No. 937 Primary Registration District No. 5519 Registrar's No. 43

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Rural White Oak
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3 Miles N of Urich
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 45 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 Mi N of Urich
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary A Armstrong
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ben Armstrong
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 7 (Month) 1 (Day) 1850 (Year)

8. AGE: Years 92 Months 7 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)
16. (a) Informant Bert Armstrong
(b) Address Urich Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 12 (Day) 43 (Year)
(c) Place: burial or cremation Carrsville Cem
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) February 12, 1943 (Date received local registrar) Georgia Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10 year 1943 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Jan 31 - 43 to Feb 9, 1943, to Feb 7, 1943; that I last saw h__ alive on ____ 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremic Poison	1-wk
Due to: Valvular Insufficiency	2 yrs
Due to: Senility	?

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

23. Signature J. G. McDonald (M. D. or other)
Address Urich Mo Date signed 2-2-43

1067

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 2-43-75
Date Filed 3-8-43

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 Fred W. Wilkerson

Licensed Embalmer No. 2476

P. O. Address Clinton

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10310

Registration District No. 137 Primary Registration District No. 6519 Registrar's No. 43

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Henry
(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 (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Mary A. Armstrong
3. (b) If veteran, name war 0
3. (c) Social Security No. 0

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 1 (Day) 1850 (Year)
8. AGE: Years 92 Months 7 Days 9 If less than one day hr. min.
9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19 ;
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremic Poison	1
Due to Valvular Insufficiency	0
Due to Senility	
Other conditions Chronic Paresky 39 (Include pregnancy within 3 months of death) — malaria Nephritis ?	

Major findings:
Of operations
Of autopsy

131 F

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature J. G. McDonald (M. D. ~~or other~~)
Address Date signed