

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22744

State File No. _____

Registrar's No. 7068

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 5 days
(Specify whether _____)
In this community 28 years
(years, months or days)

3. (a) PRINT FULL NAME

James Armstrong

3. (b) If veteran, name war _____

3. (c) Social Security No. 190-14-8803

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Malinda Armstrong 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased 8 12 1893
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Unknown Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Robert Armstrong

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

14. Maiden name Rosa ?

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

16. (a) Informant Malinda Armstrong

(b) Address 1902a N. Taylor Ave

17. (a) Burial (b) Date thereof 8-6-43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director People's Undertaking Company

(b) Address 3100 Franklin Avenue

19. (a) 3100 (b) J. F. Budeck
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, 9 11
(If outside city or town limits, write "RURAL")
(d) Street No. 1902 N. Taylor
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2,
year 1943 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 28, 1943 to August 2, 1943;
that I last saw him alive on August 2, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Autopsy: Carcinoma Pancreas Liver and Colon Metastases Unk.

Due to Primary site in Pancreas

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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? _____

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

23. Signature J. M. Jackson (M. D. or other) _____
Address 2601 W. 11th Date signed 8/3/43

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.....

James G. Pettus

Licensed Embalmer No. *4184*

P. O. Address.....

A. Lewis, Jr.

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.