

FILED JAN 15 1945

Registration District No. 6

Primary Registration District No. 5236

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Rural - Box Township
(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 ROBERT C ARMSTRONG

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 29 1930
(Month) (Day) (Year)

8. AGE: Years 14 Months 6 Days 0 If less than one day hr. min.

9. Birthplace Cedar Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at school

11. Industry or business

12. Name Bernice Armstrong
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Leeper
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Minnie Goodright

(b) Address R 3 Eldorado Springs Mo
17. (a) Burial (b) Date thereof 12-31-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clintonville Mo

18. (a) Signature of funeral director Wm. S. Sells

(b) Address Eldorado Springs Mo

19. (a) 1/2/45 (b) J. H. H. H. H.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Box Township
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1944 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 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 Natural Causes
probable Influenza

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 238

Major findings: Of operations _____
Of autopsy no

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 3

23. Signature M. D. Gurn (City or town) _____
Address Eldorado Springs Mo Date signed 12/31/44

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

RECEIVED
District Health Officer No. 76
District Health Officer No. 76
12-44-1543
1-18-45

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

O B Sider

Licensed Embalmer No.

3250

P. O. Address

El Dorado Springs Mo.

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.