

Registration District No. **170**

Primary Registration District No. **3033**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Laclede**

(b) City or town **Lebanon**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Wallace Memorial 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether years, months or days)

In this community **entire life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Laclede**

(c) City or town **Lebanon**
(If outside city or town limits, write "RURAL")

(d) Street No. **Route # 1**
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Fredia Amelia Armstrong

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month **July** day **30** year **1946** hour **10** minute **30** A.M.

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

21. I hereby certify that I attended the deceased from July 29, 1946 to July 30, 1946; that I last saw her alive on July 30, 1946; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife **William W. Armstrong** 6. (c) Age of husband or wife if alive **29** years
7. Birth date of deceased **May 1868**
(Month) (Day) (Year)

Immediate cause of death **Cerebral hemorrhage** Duration **1 day**

8. AGE: Years **78** Months **2** Days **1** If less than one day **hr. _____ min. _____**

Due to **hypertension** **unk.**

9. Birthplace **Michigan** (City, town, or county) _____ (State or foreign country) **1**

Due to _____

10. Usual occupation **Housewife**

Other conditions **430**
(Include pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN

12. Name William Rhoades 1

13. Birthplace Michigan (City, town, or county) _____ (State or foreign country) _____

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

14. Maiden name Elizabeth Ann Rash

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

16. (a) Informant Mrs C. J. Bennett
(b) Address Lebanon Mo.

17. (a) Burial (b) Date thereof **8-1-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland Cemetery

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? _____

18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.

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

19. (a) August 24, 1946 (b) **Chas. Stankburger**
(Date received local registrar) (Registrar's signature)

23. Signature James S. Hope (M. D. or other) _____
Address Lebanon, Mo. Date signed **8/1/46**

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

1
2

26411

6 E 118

Received 8-26-46

Laclede County Health Unit

File No. 7-46-~~20~~ 118

Date Filed 8-29-46

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.