

Registration District No. **43**

Primary Registration District No. **3007**

State File No. _____

Registrar's No. **172**

1. PLACE OF DEATH:
(a) County **Butler**
(b) City or town **Poplar Bluff**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Poplar Bluff Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 hours**
(Specify whether years, months or days)
In this community **6 years**

3. (a) PRINT FULL NAME **RUBY JEWELLDEAN ARMES**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **H. F. Armes** 6. (c) Age of husband or wife if alive **35** years
7. Birth date of deceased **December 2, 1924**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	22	9	17	hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **J. N. LaRue**
13. Birthplace **Missouri** (City, town, or county) (State or foreign country)
14. Maiden name **Eva Rowland**
15. Birthplace **Arkansas** (City, town, or county) (State or foreign country)

16. (a) Informant **H. F. Armes**
(b) Address **Doniphan, Missouri**
17. (a) **// Burial** (b) Date thereof **3-23-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Corning Cemetery**

18. (a) Signature of funeral director **P. R. York**
(b) Address **Walnut Ridge, Ark**
19. (a) **4-26-47** (b) **R. M. Mettler**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Ripley**
(c) City or town **Doniphan** (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 **March** day **19** year **1947** hour **6:30** minute **A** M.
21. I hereby certify that I attended the deceased from **March 19 1947** to **March 19 1947**; that I last saw h. **or** alive on **March 19 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage from Inversion of Uterus**
Due to **Pregnancy**
Due to **Labour (Pregnancy)**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
43c
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **Frank E. Jewell** (M. D. or other) **44-17**
Address **Poplar Bluff** Date signed **3/19/47**

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2

District File Number 547-642

Date Filed 5-5-47

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.....

working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 177

Registration District No. 43 Primary Registration District No. 3007

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Poplar Bluff
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ruby J Armer
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 2 (Month) (Day) (Year)

8. AGE: Years 22 Months 9 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal) (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 MAY 19 1947
year _____ month _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____
Due to _____
Due to Delivery of normal female
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____
1430

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 F. E. Duveller (M. D. or other) MD
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

12591