

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 3 1947
Registration District No. 217

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 5787

State File No. 18175
Registrar's No. 38

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston, Rural
(c) Name of hospital or institution:
4 mi. E. of Charleston
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
All of Life (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
Charleston, Rural
(c) City or town Charleston, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 mi. E. of Charleston
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 23rd
year 1947 hour 1:00 minute 30 P.M.

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive 3 years
7. Birth date of deceased April 3, 1930
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Attended as Coroner, 1947 to Coroner, 1947; that I last saw him alive on Coroner, 1947; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
17 1 20 hr. min.

Immediate cause of death Accidental Drowning
Due to

9. Birthplace Wyatt, Missouri
(City, town, or county) (State or foreign country)

Due to Boat capsized in midstream of ditch
due to twin
Other conditions (e.g., pre-existing conditions, etc.)

10. Usual occupation Farm-boy
11. Industry or business Farming

Major findings: Of operations 1937
Of autopsy hip
ALL PHYSICIAN SURVEILLANCE BY REGISTERED PHYSICIAN

MOTHER FATHER { 12. Name James Armstrong
13. Birthplace Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Morris
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Moore
(b) Address R#3, Charleston, Missouri
17. (a) Burial (b) Date thereof 5-25-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery Charleston, Missouri

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 Joe R. Neimelue
(b) Address Charleston, Missouri
19. (a) 5-31-47 (b) Mrs. John Bondurant
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury 3
23. Signature Phys. F. J. ...
Address Charleston, Mo. Date signed 5-24-47

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

RECEIVED

District Health Office No. 2,

District File Number 647-29

Date Filed 6-2-47

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Edward E. Pennington*

Licensed Embalmer No. 4164

P. O. Address: *Charleston, W. Va.*

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.

JUN 4

State File No. _____

Registrar's No. 58

1947

Registration District No. 217

Primary Registration District No. 5787

1. PLACE OF DEATH:

(a) County Mississippi
(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

3. (a) PRINT FULL NAME Clarence Armstrong

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased April 3
(Month) (Day) (Year)

8. AGE: Years 17 Months _____ 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 _____

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 23
year 1947 hour _____ 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 _____

Duration _____

Due to _____

Due to _____

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) Accident

(b) Date of occurrence May 23, 1947

(c) Where did injury occur? No injury
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no injury

While at work? no (Specify type of place) (e) Means of injury no

23. Signature Dr. Charles W. Moore (M. D. or other) _____

Address Charleston MO Date signed 6-16-47

SUPPLEMENTAL

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

18175