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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18176

State File No. _____

Registration District No. 217

Primary Registration District No. 5787

Registrar's No. 579

1. PLACE OF DEATH:

(a) County Mississippi

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

(c) Name of hospital or institution:
4 mi. E. of Charleston 3
(If not in hospital or institution, write street number or location)

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

In this community All of Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Willis Armstrong

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 2 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 _____ years

7. Birth date of deceased October 20, 1935
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
11	7	3	hr. min.

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

10. Usual occupation School-boy

11. Industry or business None

12. Name Rufus Armstrong

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

14. Maiden name Rebecca Coleman

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

16. (a) Informant Rufus Armstrong

(b) Address Charleston, R#3, 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

18. (a) Signature of funeral director Joe R. Nunnelle

(b) Address Charleston, Missouri

19. (a) 5-31-47 Mrs. Plus Bondurant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(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 _____

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from Attended as Coroner 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Accidental drowning Duration _____

Due to _____

Due to Boat capsized in main stream of ditch

Other conditions Unable to swim
(Include pregnancy within 9 months of death)

Major findings: Of operations _____

Of autopsy 187

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 John F. Nunnelle (M.D. or other) _____
Address Charleston, Mo Date signed 5-28-47

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be charged statistically.

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

67000

RECEIVED

District Health Office No. 2

District File Number 647-74

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. Munnellee

Licensed Embalmer No. 4164

P. O. Address Charleston, 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.

Registration District No. 217Primary Registration District No. 5787State File No. _____
Registrar's No. 59

1. PLACE OF DEATH:

- (a) County Mississippi
 (b) City or town Quincy
 (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 days3. (a) PRINT FULL NAME Willis Amstrong

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

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

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

7. Birth date of deceased
- Oct 20 1900
-
- (Month) (Day) (Year)

8. AGE: Years 11 Months 10 Days 10 (If less than one day) _____ hr. _____ min.

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

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 _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (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
- 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 _____

23. Signature
- John F. Fumelle
- (M. D. or other) _____

Address Charleston, Mo Date signed 6-16-47

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

SUPPLEMENTARY

JUN 4 1947

FILED

18176