S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23621

Registration District No. 52 Primary Registration District No. 5183 Registrar's No. 57

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Rural Cape Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Farm
(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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cape Gir
(c) City or town: Rural Poor House
(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 .....

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

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Dec 1868 (Month) (Day) (Year)

8. AGE: Years: 79 Months: Days: If less than one day ..... hr. ..... min.

9. Birthplace: Ohio (City, town, or county) (State or foreign country)
10. Usual occupation: None
11. Industry or business: Not Known
FATHER
12. Name: Not Known
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Not Known
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs John Harrell
(b) Address: Cape Girardeau Mo RFD
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation: County Farm
18. (a) Signature of funeral director: McCulloch & Co
(b) Address: Jackson Mo
19. (a) 8-5-47 (Date received local registrar) (b) D. G. Sieber (Registrar's signature) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 5 year: 1947 hour: 8 minute: 15 P.M.
21. I hereby certify that I attended the deceased from Feb 5, 1945 to Aug 5, 1947 that I last saw him alive on July 29, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	3 Yr
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) .....
(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: D. G. Sieber (M. D. or other) M.D.
Address: Jackson Mo Date signed: 8-5-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 847-1052

Date Filed 8-12-47

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.....

Not Embalmed

Licensed Embalmer No.....

P. O. Address.....

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.