

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1948

Registration District No. 57

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4049

State File No. 7837

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Boone
(b) City or town CENTRALIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hulens Convalescent Home #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 days (Specify whether
in this community ENTIRE LIFE years, months or days)

3. (a) PRINT FULL NAME Robert Lee ARMSTRONG

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mollie ARMSTRONG 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased October - 28 1864 (Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 11 If less than one day hr. min.

9. Birthplace Boone County MISSOURI (City, town, or county) (State or foreign country)

10. Usual occupation Retired FARMER

11. Industry or business L

12. Name JIM ARMSTRONG
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
14. Maiden name SUSAN FRENCH
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant MRS IRA HENRY
(b) Address HALLSVILLE, MISSOURI

17. (a) BURIAL (b) Date thereof 4-11-48 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CENTRALIA, MISSOURI

18. (a) Signature of funeral director BALCH FUNERAL SERVICE
(b) Address CENTRALIA, MISSOURI

19. (a) 4-10-48 (b) Maud Mc Bride (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town CENTRALIA 10
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9
year 1948 hour 12 minute 40 AM.

21. I hereby certify that I attended the deceased from About, 2 years to 4/8/48
that I last saw him alive on 4/8/48 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive - (Lobes) pneumonia Duration 20y -
Due to Smoking
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?

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

23. Signature [Signature] (M.D. or other)
Address Centralia MO Date signed 4/10/48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed APR 13 1948

AUG 2 1949

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 *Paul J. Baller*

Licensed Embalmer No. *4206*

P. O. Address *Centerville, 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.