

S. No. 2  
M-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 8 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37827  
State File No. 10205  
Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5535 Maple  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... 46 years  
years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5535 Maple  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Mrs. Nellie May Armstrong  
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 W. 2  
6. (b) Name of husband or wife James L. Armstrong, Dec. 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased March 12 1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 23  
year 1948 hour 4:05 minute 00 P. M.  
21. I hereby certify that I attended the deceased from Nov 15 1946 to Nov 23 1948  
that I last saw her alive on Nov 22 1948  
and that death occurred on the date and hour stated above.

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

Immediate cause of death Chronic Myocarditis Duration 34 years  
Due to.....  
Due to.....  
Other conditions arterio sclerosis  
(Includes pregnancy within 3 months of death)

9. Birthplace Fort Fairfield, Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Major findings:  
Of operations.....  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business.....  
12. Name Joseph Fisher  
13. Birthplace England  
(City, town, or county) (State or foreign country)  
14. Maiden name Phoebe, Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Lewis F. Armstrong  
(b) Address 5535 Maple  
17. (a) burial (b) Date thereof 11-26-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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 for about home, on farm, in industrial place, in public place?  
While at work..... (Specify type of place) (e) Means of injury.....

(c) Place: burial or cremation Valhalla  
18. (a) Signature of funeral director Alexander Sainp  
(b) Address 6175 Delmar  
19. (a) NOV 24 1948 (b) John DeSater  
(Date received local Registrar) (Registrar's signature)

23. Signature Hugh Turner (M. D. Blainstone)  
Address 1251 Blainstone Date signed Nov 24-1948

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

MOTHER FATHER

Dr. Ruth Turner  
1251 12th St. Boston  
MA 02130

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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..... *Jos. E. McCulloch* .....

Licensed Embalmer No. *2460* .....

P. O. Address..... *4175 Dillman* .....

**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.**