

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19149

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 537

1. PLACE OF DEATH a. COUNTY CRANE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Morrisville	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Kurat.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) James	b. (Middle) Robert	c. (Last) Armstrong	4. DATE OF DEATH (Month) (Day) (Year) June 15, 1949
--	---------------------------	----------------------------	---

5. SEX male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 19, 1864	9. AGE (In years last birthday) 84	10. UNDER 1 YEAR (Months) (Days) 11 20	11. UNDER 100 HRS. (Hours) (Min.)
--------------------	-------------------------------	--	---------------------------------------	---	---	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groceryman	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Knox County, Tenn	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	---

13a. FATHER'S NAME James N. Armstrong	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Dicy Armstrong
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Mrs Marie Tender	ADDRESS Mt Vernon Mo
---	---	--	--------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure with auricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH 1 yr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		4331
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Colon		approx 6 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **5-20**, 19**49**, to **6-15**, 19**49**, that I last saw the deceased alive on **6-15**, 19**49** and that death occurred at **8 A** m., from the causes and on the date stated above.

23a. SIGNATURE Fred R. Fritchling M.D.	(Degree or title)	23b. ADDRESS Med City Bldg Springfield, Mo	23c. DATE SIGNED 6/15/49
--	-------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE June 17, 1949	24c. NAME OF CEMETERY OR CREMATORY Slagle Cemetery	24d. LOCATION (City, town, or county) (State) Slagle Mo
---	-----------------------------------	--	---

DATE REC'D BY LOCAL REG 6/15/49	REGISTRAR'S SIGNATURE W.S. Handley	FUNERAL DIRECTOR'S SIGNATURE Blue Bolivar, Mo	ADDRESS
---	--	---	---------

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

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Edward B. Brown

Student Embalmer

Licensed Embalmer No.

3092

P. O. Address.....

Bellevue, W.

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.