

300  
48

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

FILED JAN 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40660

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 94 PRIMARY REG. DIST. NO. 5348 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Housburg</u>	c. LENGTH OF STAY (In this place) <u>9 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Louisburg</u> <u>36</u>	
d. FULL NAME OF (If not in hospital institution, give street address of location) <u>HOSPITAL OR INSTITUTION</u>		d. STREET ADDRESS (If rural, give location) <u>6</u>	

3. NAME OF DECEASED (Type or Print) <u>VIE OREN ARMSTRONG</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>12-10-49</u>
--	------------	-------------	-----------	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-8-1909</u>	9. AGE (In years last birthday) (If under 1 year: Months) (Days) (If under 24 hrs: Hours) (Min.) <u>40</u>
-----------------------	----------------------------------	--	--------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>(Invalid) retired</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	---	--	--

13a. FATHER'S NAME <u>JAMES H. ARMSTRONG</u>	13b. MOTHER'S MAIDEN NAME <u>DELLA HENLEY</u>	14. NAME OF HUSBAND OR WIFE <u>LEONA ARMSTRONG</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>LEONA ARMSTRONG</u>	ADDRESS <u>Housburg</u>
--	-------------------------	---	----------------------------

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		INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary tuberculosis</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>P</u>  DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>NO</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (m.)	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 Jan 12, 1949, to Dec 10, 1949, that I last saw the deceased alive on Dec 1, 1949, and that death occurred at 9208 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. D. Bailey</u>	23b. ADDRESS <u>Wilsons Mo</u>	23c. DATE SIGNED <u>Dec 14</u>
---	-----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Louisburg Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Louisburg Missouri</u>
--	------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>12-31-49</u>	REGISTRAR'S SIGNATURE <u>Miss J. B. Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Jones</u>	ADDRESS <u>Buffalo, Mo.</u>
---	--	--	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7

District File Number 12-49-1

Date Filed 1-3-50

**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 Mrs B Jones

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4329

P. O. Address Buffalo, 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.