

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# -60-014342

FILED VS MAY 16 1960 REG. NO. 43 A2412 Primary Registration District No. 3007 Registrar's No. 262 STATE FILE NUMBER

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| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>BUTLER</b><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b> Length of stay in 1b <b>1 DAY</b> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>ARKANSAS</b> b. COUNTY <b>MAMM FULTON</b><br>c. CITY OR TOWN <b>MAMMOTH SPRING</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS <b>NONE</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <b>ORVILLE</b> Middle <b>"L"</b> Last <b>ARMSTRONG</b>  |  | <b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>23</b> Year <b>1960</b>  |  |

|  |                               |   |                                  |  |  |   |
|--|-------------------------------|---|----------------------------------|--|--|---|
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>10/22/94</b> | 9. AGE (last birthday) <b>65</b>                                 | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>MAINTENANCE</b>  |                                  | 11. BIRTHPLACE (City and state or country) <b>ASH FLAT, ARK.</b> |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b> |

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|---|--|---|
| 13a. FATHER'S NAME <b>JOHN B. ARMSTRONG</b>   | 13b. MOTHER'S MAIDEN NAME <b>SARAH JACKSON</b> | 14. NAME OF HUSBAND OR WIFE <b>BERTHA ARMSTRONG</b>                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b> | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>         | 17. INFORMANT Address <b>BERTHA ARMSTRONG, MAMMOTH SPRING, ARK. *WIFE</b> |

|  |  |  |
|--|--|--|
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT, ACUTE, LEFT.</b><br>DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE, CHRONIC.</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4-5-Days</b><br><br>Unknown   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>1. PULMONARY EMPHYSEMA, BILATERAL, CHRONIC. 2. NEPHROSCLEROSIS, CHRONIC.</b>   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|--|--|-----------------------------------|--|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/>   | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____  |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                   |  |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>VA</b>   |  | 20f. CITY, TOWN, OR LOCATION <b>VA</b>   |                                   | COUNTY _____ STATE _____   |  |
| 21. I attended the deceased from <b>April 22, 1960</b> to <b>April 23, 1960</b> and last saw her/him alive on _____<br>Death occurred at <b>7:28 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |                                   |  |  |

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 22a. SIGNATURE <i>J. Lester Harwell, M.D.</i> (Regist. or Cert.)              |                                 | 22b. ADDRESS <b>VA Hospital, Poplar Bluff, Mo.</b>           | 22c. DATE SIGNED _____  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                       | 23b. DATE <b>April 26, 1960</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b> | 23d. LOCATION (City, town, or county) (State) <b>Mammoth Spring, Arkansas</b> |
| 24. FUNERAL DIRECTOR ADDRESS <b>Bryson Funeral Home, Mammoth Spring, Ark.</b> |                                 | 25. DATE REC'D. BY LOCAL REG. <b>5/3/60</b>                  | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i>                                  |

DOCUMENT  
  
MEDICAL CERTIFICATION  
  
BY AFFIDAVIT OF

MAY 24 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Ernest Eugene Clary Student Embalmer No. 602  
working under my personal supervision.

Student Ernest Eugene Clary  
Signature of Student Embalmer

Signed

John D. Clary

Licensed Embalmer No. 4475

P. O. Address Box 3980

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.