

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027888

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 61

FILED AUG 15 1962	
1. PLACE OF DEATH	
a. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b> Length of stay in lb <b>39 yrs.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>608 S. Locust St.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
c. CITY OR TOWN <b>Charleston</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <b>608 S. Locust St.</b> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last	
<b>Major Armstrong</b>	
4. DATE OF DEATH Month Day Year <b>August 6, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/92</b>
9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <b>Crittendon County, Miss.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>James Armstrong</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Rags</b>
14. NAME OF HUSBAND OR WIFE <b>Sallie Armstrong</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.
17. INFORMANT <b>James Armstrong, 610 S. Locust, Charleston, Mo.</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Uremia</b>	
DUE TO (b) <b>Arterio Sclerosis</b>	
DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m. 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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>7-5-62</b> to <b>8-6-62</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>8-6-62</b> Death occurred at <b>11:40 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <b>510 South Main Charleston Mo</b>
	22c. DATE SIGNED <b>8-9-62</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/13/62</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>	
24. FUNERAL DIRECTOR <b>R.P. Sparks</b> ADDRESS <b>Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-10-62</b>
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

VS 300 Rev. 4/59  
2675  
20675  
3  
4 2  
5 2  
6  
7 1  
8 0  
9 4500  
10  
11  
12 90-0  
13 1-0

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AUG 17 1962

Permit issued  
8-10-62  
JH

**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.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John A. Carter  
Licensed Embalmer No. 1498  
P. O. Address 2110 2nd St

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.