

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Henry
Township Davis
or
Village Clinton Rd.
or
City (NO. St. Ward)

Registration District No. 355
Primary Registration District No. 5497

File No. 34036
Registered No.

If death occurred in a hospital or institution, give its NAME instead of street and number.

2 FULL NAME Otis Jr Armstrong

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH 11 8 1914
(Month) (Day) (Year)

7 AGE 6 yrs. 30 ds.
If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (City or town, State or foreign country) La Due

PARENTS
10 NAME OF FATHER Otis Armstrong
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Mrs Lutzger
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. O. Armstrong
(Address) Montrose

15 Filed Dec 3 1914 J. P. [Signature]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11-28-20
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 11-12-20 1920, to 11-28-20 1920, that I last saw him alive on 11-27-20 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:
Typhoid
115A 100
36 (Duration) yrs. mos. 26 ds.

CONTRIBUTORY Septicemic Infection
(Secondary) (Duration) yrs. mos. 10 ds.

(Signed) W. Kelly M. D.
911-28-1920 (Address) La Due

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Stones Chapel DATE OF BURIAL Nov. 29, 1914

20 UNDERTAKER James Wilcox ADDRESS Clinton Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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CERTIFICATE OF DEATH**

1 PLACE OF DEATH

County
 Township
 or Village
 or City
 Registration District No. File No.
 Primary Registration District No. Registered No.
 City St. Ward)
 (NO.)
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 5 SINGLE
 4 COLOR OR RACE MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6 DATE OF BIRTH 1 (Year)
 (Month) (Day) 191.....

7 AGE
 If LESS than 1 day hrs.
 or min. ?
 yrs. mos. ds.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
 (City or town, State or foreign country)

10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)
 15 Filed 191....., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191....., to 191....., that I last saw h..... alive on 191..... and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

..... yrs. mos. ds.
 (Duration) yrs. mos. ds.
 (Duration) yrs. mos. ds.
 (Signed) M. D.
 191..... (Address).....

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
 20 UNDERTAKER ADDRESS