

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

Do not use this space  
34020  
4473

**1. PLACE OF DEATH**

County Jackson  
Township Blue  
City Leeds, Mo. (No. 1 B, Hosp)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Armstrong, John  
(a) Residence No. 535 General Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hollie Armstrong  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-23-1881  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
48 6 3

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Druggist  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Armstrong  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Scotland  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Emma Linn  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England  
(STATE OR COUNTRY)

14. INFORMANT K.C. T.B. Hospital  
(Address) Leeds, Mo.

15. FILED 10/30/29 M.M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 26 1929  
17. I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to Oct. 26, 1929 that I last saw him alive on Oct. 26, 1929, and that death occurred, on the date stated above, at 4 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Pulmonary Tuberculosis  
339  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) NI  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Microscopical  
(Signed) Dr. O. Bee, M. D.  
10/27/29 (Address) 1002 Angelle Bldg. N.E.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wm. Washington DATE OF BURIAL 10-31-29  
20. UNDERTAKER Mrs. C. L. Jarrett ADDRESS K.C. Mo.

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

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.

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8/10

1632. *Arctostaphylos*

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