

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

RECD JUN 12 1939

791  
1003

16583  
Do not use this space.

4117

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City..... St. Louis (d) Street No..... Homer G. Phillips Hospital..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 656 Armour

(a) Residence, No. 3028 Hickory St. 18  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2 - 20 - 39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hr. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....  
 9. Industry or business in which work was done, as saw mill, bank, etc.....  
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) St. Louis,  
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME James Armour

14. BIRTHPLACE (CITY OR TOWN) Tenn.  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Georgia Morgan

16. BIRTHPLACE (CITY OR TOWN) Starkville,  
 (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Cather Mays Sherard  
2601 N. Whittier

18. BURIAL, CREMATION, OR REMOVAL  
CITY CEMETERY DATE 4-21-39

19. FUNERAL DIRECTOR (NAME) Geo Hamilton  
 (ADDRESS) City Health Dept.

20. FILED MAY 2 1939 J. B. Brubaker  
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 20 - 19 39

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 2:55 P. M.

The principal cause of death and related causes of importance were as follows:

Premature Stillborn

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis Clinical Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury..... 19.....  
 Where did injury occur?.....  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) J. B. Brubaker, M.D.  
 (Address) 2601 N. Whittier

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.

WWW.COURTSONLINE.INFO THIS IS A PERMANENT RECORD

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**