

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3577**

Registration District No. 757

Primary Registration District No. 5998

Registrar's No. 11

1. PLACE OF DEATH: **FILED FEB 13 1940**
(a) County St Charles
(b) City or town Rural - St Charles Township
(c) Name of hospital or institution: Emmanuel Home **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 years
In this community 17 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Charles
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. St Charles Township
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME MRS. SARIE ARMSTRONG
8. (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 16th
year 1940 hour 8 minute _____ P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Frank Armstrong 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 12th 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 17th 1934 to Jan 16th 1940, that I last saw her alive on Jan 16th 1940 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 11 Days 4 If less than one day _____ hr. _____ min.

Immediate cause of death Acute Dilatation of Heart Duration 24 hrs.
Due to Chronic Myocarditis
Due to Cor Arterios-Sclerosis 10 yrs.
Other conditions None (Include pregnancy within 3 months of death) 93C

9. Birthplace Pennsylvania (City, town, or county) _____ (State or foreign country) _____
10. Usual occupation Housewife **1**
11. Industry or business **?**
12. Name Unknown **?**
13. Birthplace Unknown **?**
(City, town, or county) _____ (State or foreign country) _____
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) _____ (State or foreign country) _____

Major findings: None
Of operations None
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Elizabeth Parker
(b) Address St. Charles, Mo.
17. (a) Buried Emmanuel Cemetery (b) Date thereof Jan 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Emmanuel Cemetery
18. (a) Signature of funeral director Harold W. Baum
(b) Address St Charles Mo 1.10
19. (a) 1/18/40 (b) Blairwood H. Steiner
(Date received local registrar) (Registrar's signature) **A**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) _____
(e) Means of injury _____
23. Signature A P. Erich Schuch (M. D. or other) **1**
Address St Charles Mo Date signed 1/21/40

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.

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..... *Arthur C. Baul*

Licensed Embalmer No. *31VV*

P. O. Address *St Charles*

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.