

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 502 Primary Registration District No. 4305

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Marceline Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Putnam Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 hrs!
(Specify whether
In this community 69 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JULIA A. ARMSTRONG

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race WHITE 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Albert Armstrong 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased Sept 9 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Chariton Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin E. Peden
13. Birthplace Ohio (State or foreign country)
14. Maiden name Susannah Munyon
15. Birthplace Ohio (State or foreign country)

16. (a) Informant's own signature Ethel Burwell

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Mar 29 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Peden Chapel

18. (a) Signature of funeral director W. M. Laughlin

(b) Address Marceline Mo 451

19. (a) 3-29-40 (b) Oliver Barrett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1940 hour 12 minute 05 A.M.

21. I hereby certify that I attended the deceased from Feb 1 - 1940
_____ 19 _____ to March 26 19 40
that I last saw her alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Thrombosis Duration 4 days

Due to Phlebitis 34 days

Due to ~~Septicemia~~ 100 days

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 M. L. Dukerger (M. D. or other) M.D.
Address Marceline Mo Date signed 3/28/40

RECEIVED
District Health Officer No. 111
District No. 440-524
Date Filed APR 12 1940

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 Dale Bunch
Licensed Embalmer No. 4088
P. O. Address Marceline Mo

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.