

1. PLACE OF DEATH:  
(a) County Genesee  
(b) City or town Pascala  
(c) Name of hospital or institution: home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Chas. Henry Armstrong  
3. (b) If veteran, name war No. 3. (c) Social Security No. 770.

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 11 - 1859  
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace See  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant J. D. Marshall  
(b) Address Pascala

17. (a) Burial (b) Date thereof Jan 11 - 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ingram Ridge

18. (a) Signature of funeral director Richard Mitchell  
(b) Address Rectory Ark

19. (a) Jan 11 - 41 (b) Mrs T. R. Cole  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Genesee  
(c) City or town Pascala  
(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. ? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10  
year 1941 hour 9 minute 15 a. m.  
21. I hereby certify that I attended the deceased from Jan 7  
1941 to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on Jan 7, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 4 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Senility, Dry gangrene of both feet

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?

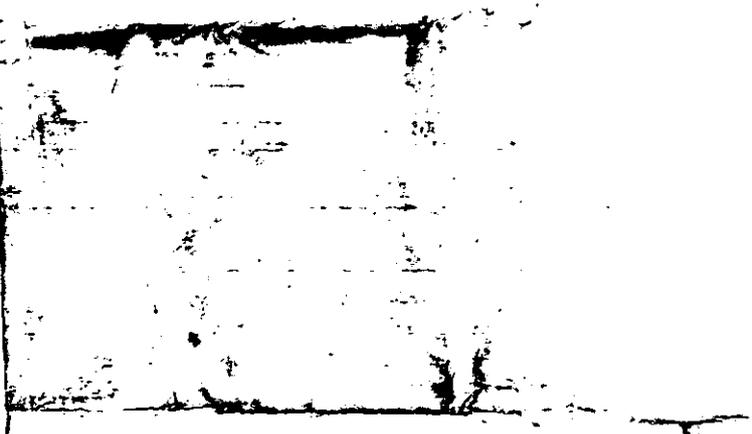
591 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Arberry (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8000

2-41-3



**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3732

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1102

Primary Registration District No. 5870

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Pemiscott  
(b) City or town Pascagoula  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME

Chas Henry Armstrong

(b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 11 1859  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 2 29 \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace wh \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name ok \_\_\_\_\_

15. Birthplace ok \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan 11-41 (b) Mrs J R Cole  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 10  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 G Shurey (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

