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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 30 1945

State File No. 22792

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2953

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2023 Flora 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town K C
(If outside city or town limits, write "RURAL")
(d) Street No. 2023 Flora ave 3 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 5
If yes, name country

3. (a) PRINT FULL NAME Sallie Armistead
3. (b) If veteran, name war no
3. (c) Social Security No. None

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct ~~July~~ 24 1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 20 If less than one day hr. min.

9. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 6
(City, town, or county) (State or foreign country)
16. (a) Informant M Xenia Armistead
(b) Address 2023 Flora ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18 45
(Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery
18. (a) Signature of funeral director H B Moore
(b) Address 1820 E 18 st
19. (a) 7-16-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14
year 1945 hour 3:15 a.m. minute M.
21. I hereby certify that I attended the deceased from July 10, 1945 to July 13, 1945;
that I last saw her alive on July 13, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia due to Acute Congestive Heart Failure.

~~Due to~~

~~Due to~~

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) None
(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?
(Specify type of place)
While at work? (e) Means of injury 0
23. Signature George H. Taft (M. D. or other)
Address 2123 E. 15th St Date signed 7/16/45

(Licensed Embalmer's Statement on Reverse Side)

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 H B Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 68 st

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, fact should be so stated above.