

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2619

FILED JUL 3 1948  
Registration District No. 149

Primary Registration District No. 1002

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

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:  
GENERAL HOSPITAL NO. 2 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 167 DAYS  
(Specify whether in this community 24 YRS. years, months or days)

3. (a) PRINT FULL NAME JOSEPH ARMSTRONG

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE 2

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOSEPHINE ARMSTRONG

6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased: JUNE 4 1892  
(Month) (Day) (Year)

8. AGE: Years 56 Months 0 Days 17  
If less than one day hr. min.

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

10. Usual occupation LABORER

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

MOTHER FATHER { 12. Name SAMUEL ARMSTRONG

13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

14. Maiden name CARRIE

15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant JOSEPHINE ARMSTRONG (WIFE)

(b) Address 1401 EUCLID

17. (a) Burial (b) Date thereof 6-24-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 12th W.C. Mo.

19. (a) 6-23-48 (b) Gerardine Holme  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 78

(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")

(d) Street No. 1401 EUCLID  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 21,  
year 1948 hour 12: minute 05 A. M.

21. I hereby certify that I attended the deceased from JANUARY  
16, 1948 to JUNE 21, 1948.

that I last saw h. IM alive on JUNE 21, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death HYPERTENSIVE HEART  
DISEASE

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

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

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work 0 (Specify type of place) \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address GENERAL HOSPITAL NO. 2 Date signed 6/21/48

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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 C. Kenneth Kerford  
Licensed Embalmer No. 4437  
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, fact should be so stated above.