

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5874**  
Registrar's No. **1964**

BIRTH NO. **FILED MAR 8 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>St. Louis,</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5722 Kingsbury</b>		e. STREET ADDRESS (If rural, give location) <b>5 5722 Kingsbury</b> <b>2059</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Allen</b> b. (Middle) <b>Franklin</b> c. (Last) <b>Armstrong</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 1, 1954.</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 14, 1881</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Watchman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Graves County Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Robert F. Armstrong</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Rebekah Newton</b>	14. NAME OF HUSBAND OR WIFE <b>Clara P. Armstrong.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Jack Silvey,</b>	ADDRESS <b>5722 Kingsbury.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b> <b>2-3 Years</b> <b>Years</b> <b>19 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute myocardial failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertension essential</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Bilateral deafness</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
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22. I hereby certify that I attended the deceased from **Sept 15, 1953**, to **March 1, 1954**, that I last saw the deceased alive on **Feb 28, 1954**, and that death occurred at **9:45 p.m.**, from the causes and on the date stated above.

23. SIGNATURE <b>Samuel D. Keady</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>730, Hodgson</b>	23c. DATE SIGNED <b>2/2/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3-2-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Water Valley Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Water Valley, Kentucky.</b>
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DATE REC'D BY LOCAL REG. <b>MAR 2 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 ....., Student Embalmer No. .... working under my personal supervision. .

Student.....  
Signature of Student Embalmer

Signed.....  
*Fred J. Larned*

Licensed Embalmer No. ....  
*H. J.*

P. O. Address.....  
*H. J. Larned*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**