

FILED MAR 7 1955

STANDARD CERTIFICATE OF DEATH

State File No. 5958

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1699

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY 0   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) St. Louis |  | c. CITY OR TOWN St. Louis  |  |
| c. LENGTH OF STAY (In this place) 37 yrs.                                  |  | 4. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hosp. d 2/7      |  | e. STREET ADDRESS (If rural, give location) 3151 (Basement) Sheridan   |  |

|  |  |             |  |                    |  |  |  |
|--|--|-------------|--|--------------------|--|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) JOHN |  | b. (Middle) |  | c. (Last) ARMSTEAD |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>Feb. 18, 1955 |  |
|--|--|-------------|--|--------------------|--|--|--|

|               |  |                        |  |  |  |                                |  |                                    |  |               |  |            |  |             |  |            |  |
|---------------|--|------------------------|--|--|--|--------------------------------|--|------------------------------------|--|---------------|--|------------|--|-------------|--|------------|--|
| 5. SEX Male 2 |  | 6. COLOR OR RACE Negro |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married |  | 8. DATE OF BIRTH Apr. 18, 1889 |  | 9. AGE (In years last birthday) 65 |  | 10. MONTHS 10 |  | 11. DAYS 0 |  | 12. HOURS 0 |  | 13. MIN. 0 |  |
|---------------|--|------------------------|--|--|--|--------------------------------|--|------------------------------------|--|---------------|--|------------|--|-------------|--|------------|--|

|   |  |  |  |   |  |  |  |                                     |  |  |  |
|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher |  | 10b. KIND OF BUSINESS OR INDUSTRY Krey Packing Co. |  | 11. BIRTHPLACE (City and State or Foreign Country) Starksville, Mississippi |  |  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |  |  |  |
|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|

|                                   |  |  |   |  |  |                                    |  |  |
|-----------------------------------|--|--|---|--|--|------------------------------------|--|--|
| 13a. FATHER'S NAME Allen Armstead |  |  | 13b. MOTHER'S MAIDEN NAME Classie-Unknown |  |  | 14. NAME OF HUSBAND OR WIFE Callie |  |  |
|-----------------------------------|--|--|---|--|--|------------------------------------|--|--|

|   |  |                                     |  |   |  |                     |  |
|---|--|-------------------------------------|--|---|--|---------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes |  | 16. SOCIAL SECURITY NO. 493-05-7603 |  | 17. INFORMANT'S SIGNATURE OR NAME Callie Armstead |  | ADDRESS 1320 Elliot |  |
|---|--|-------------------------------------|--|---|--|---------------------|--|

|  |  |   |  |  |  |  |  |                                  |  |
|--|--|---|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | MEDICAL CERTIFICATION   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure  |  | ANTECEDENT CAUSES   |  |  |  |  |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. |  |  |  |  |  | DUE TO (b)                       |  |
|  |  |   |  |  |  |  |  | DUE TO (c)                       |  |
| II. OTHER SIGNIFICANT CONDITIONS   |  | Conditions contributing to the death but not related to the disease or condition causing death.     |  |  |  |  |  |                                  |  |

|                        |  |                                  |  |  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 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) |  |
|--|--|--|--|---|--|

|   |  |  |  |                                 |  |
|---|--|--|--|---------------------------------|--|
| 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? 4341 |  |
|---|--|--|--|---------------------------------|--|

22. I hereby certify that I attended the deceased from 19 P. to 19 P., 19 1955, that I last saw the deceased alive on 19 1955, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

|  |  |                         |  |                          |  |
|--|--|-------------------------|--|--------------------------|--|
| 23a. SIGNATURE (Degree or title) <i>Catharine Taylor Corauer</i> |  | 23b. ADDRESS 1300 Clark |  | 23c. DATE SIGNED 2-23-55 |  |
|--|--|-------------------------|--|--------------------------|--|

|   |  |                     |  |  |  |   |  |
|---|--|---------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal |  | 24b. DATE 2/24/1955 |  | 24c. NAME OF CEMETERY OR CREMATORY National Cemetery |  | 24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo. |  |
|---|--|---------------------|--|--|--|---|--|

|                                      |  |   |  |  |  |
|--------------------------------------|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. FEB 23 1955 |  | REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHARLES J. GATES 4107 Finney Ave. |  |
|--------------------------------------|--|---|--|--|--|

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

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

Student.....  
Signature of Student Embalmer

Signed *Arthur L. Heilliard*

Licensed Embalmer No. 4221

P. O. Address 4107 Finney A

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.