

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1957

33171

STATE FILE NUMBER

8710

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>38 D.O.A. Homer Phillips, Jr.</i> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <i>1102 N. Leonard</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>Mae</i> Last <i>Armstrong</i> | | | 4. DATE OF DEATH Month <i>9</i> Day <i>15</i> Year <i>57</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>8-5-1916</i> |
| 9. AGE (In years last birthday) <i>41</i> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | 11. BIRTHPLACE (City and state or country) <i>Augusta Ark.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Unknown</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Mary Peten</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no., or unknown) (If yes, give war or dates of service) <i>-</i> | |
| 16. SOCIAL SECURITY NO. <i>490-38-5341</i> | | 17. INFORMANT <i>Odell Peten</i> Address <i>4003 Fairfax</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>Coronary heart disease</i> DUE TO (b) <i>Coronary Heart Disease.</i> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <i>9-15-57</i> <i>7-29-57</i> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>4201</i> | | 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from <i>8-13-57</i> to <i>9-13-57</i> and last saw her her alive on <i>9-13-57</i> Death occurred at <i>11:30 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>J.C. Sherard, M.D.</i> | | 22b. ADDRESS <i>2702a Franklin</i> | 22c. DATE SIGNED <i>9-16-57</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 23b. DATE <i>9-21-57</i> | 23c. NAME OF CEMETERY OR CREMATORY |
| 23d. LOCATION (City, town, or county) (State) <i>Bald-Knob Ark.</i> | | 24. FUNERAL DIRECTOR ADDRESS <i>SWAN UNDT. Co. 4481 FINNY</i> | |
| 25. DATE RECD. BY LOCAL REG. <i>SEP 17 57</i> | | 26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i> | |

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 *Leroy U. Bonmeister*

Licensed Embalmer No. *452*

P. O. Address *4251 Ave*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.