

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40033  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 1143

S. 300  
v. 1-57

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                          |                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> |                                                                          |                                                                                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>RURAL, S. CAMPBELL TWP</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                        | c. CITY OR TOWN <b>SPRINGFIELD</b>                                                                                                        |                                                                          | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>S. CAMPBELL TWN</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | Length of stay in lb<br><b>2 yrs</b>                                                                                                                        | d. STREET ADDRESS (If outside, give location)<br><b>S. CAMPBELL TWN</b>                                                                   |                                                                          | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>            |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ELVIE</b> Middle <b>ARMSTRONG</b> Last <b>ARMSTRONG</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>24</b> Year <b>1957</b>                                                                      |                                                                          |                                                                                                  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><b>White</b>                                                                       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 28, 1890</b>                                                                                                  | 9. AGE (In years last birthday)<br><b>67</b>                             | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                        | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                       | 11. BIRTHPLACE (City and state or country)<br><b>Carbon, Kentucky</b>                                                                                       |                                                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |                                                                                                  |
| 13a. FATHER'S NAME<br><b>Dr. Franklin Sullivan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 13b. MOTHER'S MAIDEN NAME<br><b>Martha Edes</b>                                                                                                             |                                                                                                                                           | 14. NAME OF HUSBAND OR WIFE<br><b>Herman Armstrong</b>                   |                                                                                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                              | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>                                                              | 17. INFORMANT Address<br><b>Mrs. Charles Suttles, Rt. #7</b>                                                                                                |                                                                                                                                           |                                                                          |                                                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden death; Chr. heart block</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>arterio-sclerosis;</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4500</b> |                                                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>(Several years)</b><br><b>11.</b><br><b>several years</b> |
| 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.)           |                                                                                                                                                             |                                                                                                                                           |                                                                          |                                                                                                  |
| 20c. TIME OF INJURY<br>Hour _____ 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 <b>March 1956</b> to <b>Date of death</b> and last saw her <b>alive on 9-11-1957</b><br>Death occurred at <b>3:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                          |                                                                                                  |
| 22a. SIGNATURE (Degree or title)<br><b>Dr. Lee Hoover M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             | 22b. ADDRESS<br><b>609 Cherry Springfield, Mo.</b>                                                                                        |                                                                          | 22c. DATE SIGNED<br><b>11/26/57</b>                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><b>11/26/57</b>                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple Park Cemetery</b>                                                                                            |                                                                                                                                           | 23d. LOCATION (City, town, or county) (State)<br><b>Aurora, Missouri</b> |                                                                                                  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>AYRE-GOODWIN, Inc. Springfield</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 25. DATE RECD. BY LOCAL REG.<br><b>11-27-57</b>                                                                                                             | 26. REGISTRAR'S SIGNATURE<br><b>Edna Williams</b>                                                                                         |                                                                          |                                                                                                  |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

DEC 8 1957

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 *James T. Bradley* .....

Licensed Embalmer No. *4815*

P. O. Address *Springfield*

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.