

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

49670-58
58-030115
State File No.

FILED AUG 28 1958

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7669

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 30 St. Louis Maternity		d. STREET ADDRESS (If rural, give location) 3127 4116 Ashland Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First)	b. (Middle)	c. (Last)	
Armstrong		July 19 1958	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH July 19 1958
9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Monzell Armstrong		13b. MOTHER'S MAIDEN NAME Bernice People	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Bernice and Monzell Armstrong	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atelectasis of lungs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Multiple congenital anomalies DUE TO (c) 762.0 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Edema	
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?		22. I hereby certify that I attended the deceased from 7-19-1958, to 7-19-1958, that I last saw the deceased alive on 7-19-1958, and that death occurred at 1:00 P. m., from the causes and on the date stated above.	
23a. SIGNATURE Philip S. Brown M.D.		23b. ADDRESS St. Louis Maternity Hospital	
23c. DATE SIGNED 7-28-58		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 8-30-58		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Lawrence Aker 4104 Manchester	
DATE REC'D BY LOCAL REG. AUG 7 58		REGISTRAR'S SIGNATURE Paul Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

Licensed Embalmer No.....

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.