Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000244
STATE FILE NUMBER

FEB 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 118

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION 719 S. 21st. St. — Length of stay in Hospital 14 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph 0117 6 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 2218 Locust St. (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Dora — Middle Mae — Last Armstrong

4. DATE OF DEATH Month Jan. Day 29 Year 1959

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] 2 **DIVORCED** [ ]

8. DATE OF BIRTH Mar. 18-1892

9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (City and state or country) Jasper, Tenn. 1

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Sam McReynolds

13b. MOTHER'S MAIDEN NAME Sarah Greer

14. NAME OF HUSBAND OR WIFE George T. Armstrong

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO. 489-38-4811

17. INFORMANT Mrs. Maude Hogue — Address 719 S. 21st. St. City

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) primary breast carcinoma — about 2 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 SEPT 1958 to 1/29/59 and last saw her/him alive on 1/28/59
Death occurred at 3:30 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald J. Stallard, M.D. (Degree or title)
22b. ADDRESS 902 Edmond St.
22c. DATE SIGNED 2/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Feb. 3-1959
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery
23d. LOCATION (City, town, or county) St. Joseph, (State) Mo.

24. FUNERAL DIRECTOR John H. Alexander — ADDRESS St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Feb 9, 1959
26. REGISTRAR'S SIGNATURE Mrs Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
Dr. Donald J. Stallard
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 John H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph

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.