

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011867

FILED VS APR 14 1960

Registration District No. 226 Primary Registration District No. 4337 Registrar's No. 20

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Monroe</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Monroe</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Madison</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Madison</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Marion St</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Marion St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Vinie</u> Middle <u>Pearl</u> Last <u>Armstrong</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>4,</u> Year <u>1960</u>	
---	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Madison, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>William Henderson Noel</u>	13b. MOTHER'S MAIDEN NAME <u>Mollie Jane Nichols</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>4224 N. Newstead St. Louis, Mo.</u> <u>William Armstrong</u>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		<u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>years</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year
--	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
---	--	---

21. I attended the deceased from September 16, 1959 to April 4, 1960 and last saw him alive on April 2, 1960
Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. F. Stauber</u> (Degree or title)	22b. ADDRESS <u>D.O. P.O. Box 97 Madison Mo.</u>	22c. DATE SIGNED <u>4-6-60</u>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Madison, Mo.</u>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Thompson-Mackler</u> ADDRESS <u>Madison, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-7-1960</u>	26. REGISTRAR'S SIGNATURE <u>Elsie Miller</u>
---	---	--

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joseph R. Mac

Licensed Embalmer No. 457

P. O. Address Madison

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