No. 2
11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37781

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4379

DEC 11 1940

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-8-40-11-14-40 (Specify whether years, months or days)
In this community 72 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 1125 Bellview St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: George Armstrong
3. (b) If veteran, name war: no
3. (c) Social Security No.: Don't Know
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Unknown
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Unknown (Month) (Day) (Year)
8. AGE: Years 77 Months — Days — If less than one day ____ hr. ____ min.
9. Birthplace: Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Common Laborer
11. Industry or business: G. L.
FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Record Clerk
(b) Address: Gen. Hosp # 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-19-40 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Lincoln K C Mo
18. (a) Signature of funeral director: Flynn & Greenlee
(b) Address: 1819 E. 15th K C Mo
19. (a) 11-18-40 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11- day 14- year 40 hour 12 minute 45 P.M.
21. I hereby certify that I attended the deceased from 11-8-40, 19__, to 11-14-, 1940; that I last saw him alive on 11-14-, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Apoplexy	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work?
(e) Means of injury:
23. Signature: [illegible] (M. D. or other)
Address: Gen. Hosp. # 2 Date signed 11-16-40

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Edw G. Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th st KC, M

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, above space should be left blank.