

FILED APR. 1 1943 99

Registration District No.

Primary Registration District No. **1002**

Registrar's No. **1028**

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 No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3-3-42-3-10-42**
(Specify whether years, months or days) **38 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. **1411 Highland**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **SHERMAN ARMSTRONG**

3. (b) If veteran, name war **no**
3. (c) Social Security No. **486-07-8785**

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Emma Armstrong**
6. (c) Age of husband or wife if alive **35** years
7. Birth date of deceased **March 13 1882**
(Month) (Day) (Year)

8. AGE: Years **59** Months **11** Days **27**
If less than one day **25** hr. min.

9. Birthplace **Ottawa Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business

MOTHER FATHER { 12. Name **John Armstrong**
13. Birthplace **Sedalia Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Baker**
15. Birthplace **LaCyne Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **General Hospital No. 2**
17. (a) **Burial** (b) Date thereof **Mar. 14 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lincoln Cemetery**
18. (a) Signature of funeral director **Adkins Bros.**
(b) Address **2000 E. 12th St. Mo.**
19. (a) **3-13-42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10**
year **1942** hour **8** minute **00 a.m.**

21. I hereby certify that I attended the deceased from **March 3** 19 **42** to **March 10** 19 **42**
that I last saw him alive on **March 10** 19 **42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Far Advanced Pulmonary Tuberculosis**
Duration

Due to **13 B1**
Due to

Other conditions (Include pregnancy within 3 months of death)

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?
While at work? (Specify type of place) (e) Means of injury.....
23. Signature **J. P. O. Thompson** (M. D. or other)
Address **Gen. Hosp #5-600 E. 12** Date signed **3-11-42**

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

148
3
8

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561

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 J Evans

Licensed Embalmer No.....

9836

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.