

S. No. 2
I-9.4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13143

State File No.

FILED MAY 10 1945
Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 25

1. PLACE OF DEATH

(a) County Clay
(b) City or town Minnierille Mo
(c) Name of hospital or institution: Horn Hall
(d) Length of stay: In hospital or institution 40 yrs
In this community 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay
(c) City or town Minnierille Mo
(d) Street No. _____
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Elsie Alphonso Armstrong

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MO 5. Color or race Wt 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Laeg Armstrong 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Sept 4-1878

8. AGE: Years 66 Months 7 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Gallatin Mo

10. Usual occupation FARMER

11. Industry or business FARMER

12. Name Henty A Armstrong

13. Birthplace Mo

14. Maiden name Susan Goodwin

15. Birthplace Mo

16. (a) Informant Mrs Laeg Armstrong

(b) Address Minnierille Mo

17. (a) Burial (b) Date thereof April 24 1945

(c) Place: burial or cremation Hyland Park, K. C. Kaspa

18. (a) Signature of funeral director Walter Funnell
(b) Address North Kansas City Mo
19. (a) Apr 24 1945 (b) Cuth N Hebray

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1945 hour 4 minute 40 P.M.
21. I hereby certify that I attended the deceased from 7-4-45
that I last saw him alive on 4/19/45
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vascular accident Duration 6 hours

Due to hypertension 2-3 yrs
Chronic myocardial 9-10 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 9/30
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address North KC, Mo Date signed 4/23/45

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

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 5/9/45

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

John S. Norton

Licensed Embalmer No. 4349

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.