

No. 2
-12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5964**
Registrar's No. **1045**

318

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)

In this community 4 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Armstrong

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Female 5. Color or race C

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sidney Armstrong

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased March 1st 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	10	28	hr. min.

9. Birthplace Oakland Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business --

12. Name Sidney Cromwell

13. Birthplace Unavailable Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Adeline Crump

15. Birthplace Unavailable Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Addie Carr

(b) Address 4346 St. Louis Ave.

17. (a) Burial (b) Date thereof 2-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paters Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) JAN 31 1947 (b) J. J. Redick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2425 N Taylor
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29
year 1947 hour 12 minute 45 A

21. I hereby certify that I attended the deceased from January 14, 1947 to January 29, 1947
that I last saw her alive on January 29, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease with De-
compensation

Duration Unk

Due to _____

Due to _____

Other conditions 9/2
(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)

(2) Means of injury 0

23. Signature E. B. Williams (M. D. or nurse)

Address 2601 No. N. Litter Date signed 1-30-47

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

MOTHER FATHER

FILED FEB 17 1947

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.....
Chas. J. Gates ~~XXXXXXXXXXXX~~ Registered Apprentice No.....
working under my personal supervision.

Signed.....
Licensed Embalmer No. ~~4059~~ 1825
P. O. Address... 4107 Finney Ave.

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.