

FILED OCT 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Huffman

State File No. 33189

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 941	
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 21 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		1396	
d. FULL NAME OF HOSPITAL OR INSTITUTION 621 S. Douglas				d. STREET ADDRESS (If rural, give location) 621 S. Douglas			
3. NAME OF DECEASED (Type or Print) Mary		a. (First) J.		b. (Middle) Armstrong		c. (Last)	
4. DATE OF DEATH		(Month) Oct.		(Day) 27,		(Year) 1950	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 16 1884	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Cincinnati Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John J. Phelon		13b. MOTHER'S MAIDEN NAME Powers		14. NAME OF HUSBAND OR WIFE Dr. A. Armstrong			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. A. Armstrong Springfield, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Thrombosis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						332X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1950 to Oct 27 1950, that I last saw the deceased alive on 26 Oct 1950, and that death occurred at 6:20 a.m., from the causes and on the date stated above.							
23a. SIGNATURE E. A. Huffman M.D. U. (Degree or title)				23b. ADDRESS Springfield Mo.		23c. DATE SIGNED 10-27-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/29/50		24c. NAME OF CEMETERY OR CREMATORY Unknown		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. 10-27-50		REGISTRAR'S SIGNATURE W. E. Handley ca 20		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. Lohmeyer Springfield, Mo.			

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Walter C Hamilton

Signed.....

Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield MO*

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.