

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospt		d. STREET ADDRESS (If rural, give location) 14 6040 Fyler Ave 2149 0	
3. NAME OF DECEASED (Type or Print) a. (First) Horace b. (Middle) G. c. (Last) Armstrong		4. DATE OF DEATH (Month) (Day) (Year) Dec 4 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 4 1871
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer	11. BIRTHPLACE (State or foreign country) Kentucky
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Owen Armstrong		13b. MOTHER'S MAIDEN NAME ? Meier	
14. NAME OF HUSBAND OR WIFE Julia Blattner Armstrong		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Dent Know		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Alma Armstrong 6040 Fyler Ave	
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Possible Myocardial Infarction	
		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Possible associated pneumonia & possibly cerebral abscess	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE 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"/>	
21d. TIME OF INJURY		21f. HOW DID INJURY OCCUR? 1991	
22. I hereby certify that I attended the deceased from Aug 1948 , to 3 Nov , 19 53 that I last saw the deceased alive on 5 Nov , 19 53 and that death occurred at 6 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Leathard		23b. ADDRESS 4807 W. Howard St	
23a. SIGNATURE		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec 7 1953	
24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. DEC 5 1953		REGISTRAR'S SIGNATURE Earl Smith md	
DATE REC'D BY LOCAL REG.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Weick Bros 2201 S. Grand Blvd	

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

Dr. W. Hoodman
4007 91 Florida Ave
Orlando 2063
Fla 275

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Ronald O. Yalaska

Licensed Embalmer No. 2917

P. O. Address St. Louis

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.