

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45042**
6153

FILED JAN 22 1954

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>3 1/2 yrs.</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>5212-SCARRITT 3078</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GRACE</u> b. (Middle) <u>NELLIE</u> c. (Last) <u>ARMSTRONG</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12-30-53</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-14-1896</u>		9. AGE (In years last birthday) <u>57</u>	If UNDER 1 YEAR Months <u>31</u>	If UNDER 4 HRS. Days <u>2</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH R. ANGEL</u>		13b. MOTHER'S MAIDEN NAME <u>CARRIE BELL FREW</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN ARMSTRONG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME AND HOME ADDRESS <u>Max Jane Brantle, Belton Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Tracheo Bronchitis</u> DUE TO (c) <u>Acute Valvular Stenosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Poenacluyctous Deg of Liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>2 wks</u> <u>Undet</u> <u>Undet</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4211</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>Nov</u> , 19 <u>53</u> , to <u>Dec 20</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>53</u> , and that death occurred at <u>10:09 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Leo M. Mullens</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>3443 Indiana St.</u>		23c. DATE SIGNED <u>12-31-53</u>	
24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JAN 2-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kansas</u>			
DATE REC'D BY LOCAL REG. <u>12-31-53</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>SHEIL FUNERAL HOME</u>			

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

FEB 28 1955

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.....
Signature of Student Embalmer

Signed *John D. Shiel*.....
Licensed Embalmer No. *B625*
P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.