

FILED SEP 9 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28286

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>263</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Hannibal</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence 412 North</u>				e. STREET ADDRESS (If rural, give location) <u>412 North</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter Armstrong</u> b. (Middle) <u>Storrs</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>August 27, 1954</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 3, 1874</u>		9. AGE (in years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 12 HRS. Days <u>24</u> Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storrs Coal Company</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>George W. Storrs</u>		13b. MOTHER'S MAIDEN NAME <u>Isabelle Morgan</u>		14. NAME OF HUSBAND OR WIFE <u>Florence Smith Storrs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Walter A. Storrs Sr. Hannibal Missouri</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>death</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				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) m.		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 <u>from 8/27/1954, to 8/27/1954</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8/27/1954</u> , and that death occurred at <u>9:30A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. G. Chilton, M.D.</u>				23b. ADDRESS <u>500 Broadway, Hannibal, Mo</u>		23c. DATE SIGNED <u>8/28/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/30/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
DATE REC'D BY LOCAL REG. <u>9/1/54</u>		REGISTRAR'S SIGNATURE <u>Wm. Lucke Co. H. C. Fisher</u>		FEDERAL DIRECTOR'S SIGNATURE <u>Wm. Lucke Co. H. C. Fisher</u>		ADDRESS <u>Hannibal Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 7 1954

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED SEP 7 1954

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 *James S. [Signature]*
.....
Licensed Embalmer No. 4540

P. O. Address Hannibal, Missouri

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.