

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1955

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>754</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Joseph</u> c. CITY OR TOWN <u>St Joseph Mo</u>			
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>St Joseph #2</u>		c. LENGTH OF STAY (If this place) <u>16 days</u>		c. CITY OR TOWN <u>St Joseph Mo</u>		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>State Hospital #2</u>				e. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Estel</u> b. (Middle) <u>Ann</u> c. (Last) <u>Armstrong</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7 25 1955</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>Abt 74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sentry County Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John</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>Not given</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rev John Armstrong Harden</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> ANTECEDENT CAUSES DUE TO (b) <u>cerebral arteriosclerosis</u> <u>10 yrs</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Psychotic</u> <u>16 days</u> Conditions contributing to the death but not related to the disease or condition causing death.					
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 <u>July 9, 1955</u> to <u>July 25, 1955</u> that I last saw the deceased alive on <u>7-24, 1955</u> and that death occurred at <u>12:45 p.m.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>G.E. Cousins M.D.</u>				23b. ADDRESS <u>State Hospital #7</u>		23c. DATE SIGNED <u>7-25-1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7/25/1955</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>St Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>July 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton - Bowman - St Joseph Mo.</u>			

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

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 P. Hawkins*.....

Licensed Embalmer No. 453

P. O. Address 319 E 10th St

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.