

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2567**
Registrar's No. **399**

FILED JAN 26 1956

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

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

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 town or town St. Louis, Mo.)		c. LENGTH OF STAY (in this place) DOA	c. CITY OR TOWN St. Louis,
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital		e. STREET ADDRESS (If rural, give location) 3737 Laclede Ave.	
3. NAME OF DECEASED a. (First) Grace b. (Middle) Katherine c. (Last) Armstrong		4. DATE OF DEATH (Month) (Day) (Year) Jan. 12, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 8, 1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
13a. FATHER'S NAME Robert Armstrong		13b. MOTHER'S MAIDEN NAME Mary Buchanan	14. NAME OF HUSBAND OR WIFE Nil.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or date of service) Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Robert Armstrong, 3737 Laclede Ave.
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningococemia ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 057-1	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS 1300 Cherokee	
23c. DATE SIGNED 1/10/56		23d. _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-13-56	
24c. NAME OF CEMETERY OR CREMATORY Wardell Cemetery		24d. LOCATION (City, town, or county) (State) Wardell, Missouri.	
DATE REC'D BY LOCAL REG. JAN 12 1956		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington,	

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 *Robert M. Murray*

Licensed Embalmer No. *3799*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.